payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPLIES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1312 Period: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/79/2018 12:04 pm

|                        |  |             |                       | 5/2  | 29/2018 1: | 2:04 pm  |
|------------------------|--|-------------|-----------------------|--|------------|----------|
| PART I - COST          | REPORT STATUS  |             |                       |  |            |          |
| Provi der              | 1. [ X ] Electronically filed  | cost report |                       | Date: 5/29/2018  | Ti me:     | 12: 04 p |
| use only               | 2. [ ] Manually submitted c  | ost report  |                       |  |            |          |
|                        | 3. [ 0 ] If this is an amende<br>4. [ F ] Medicare Utilization   |             |                       | resubmitted this cost  | report     |          |
| Contractor<br>use only | 5. [ 1 ] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended |             | this Provider CCN 12. | NPR Date:<br>Contractor's Vendor C<br>[ 0 ]If line 5, colum<br>number of times | n 1 is 4:  |          |

## PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (15-1312) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)\_\_\_\_\_\_\_Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

|        |                               |         | Title XVIII |          |       |           |         |
|--------|-------------------------------|---------|-------------|----------|-------|-----------|---------|
|        | Cost Center Description       | Title V | Part A      | Part B   | HI T  | Title XIX |         |
|        |                               | 1.00    | 2. 00       | 3. 00    | 4. 00 | 5. 00     |         |
|        | PART III - SETTLEMENT SUMMARY |         |             |          |       |           |         |
| 1.00   | Hospi tal                     | 0       | 243, 568    | 172, 670 | 0     | 0         | 1. 00   |
| 2.00   | Subprovider - IPF             | 0       | 0           | 0        |       | 0         | 2. 00   |
| 3.00   | Subprovider - IRF             | 0       | 0           | 0        |       | 0         | 3. 00   |
| 5.00   | Swing bed - SNF               | 0       | 133, 277    | 0        |       | 0         | 5. 00   |
| 6.00   | Swing bed - NF                | 0       |             |          |       | 0         | 6. 00   |
| 9.00   | HOME HEALTH AGENCY I          | 0       | o           | 0        |       | 0         | 9. 00   |
| 200.00 | Total                         | 0       | 376, 845    | 172, 670 | 0     | 0         | 200. 00 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

| Hospital and Hospital Health Care Complex Address:   | HOSPI T | AL AND HOSPITAL HEALTH CARE COMPLEX  |  |               | Provi der |         |               | Period:<br>From 01/01,<br>To 12/31, | /2017<br>/2017 | Workshe<br>Part I<br>Date/Ti<br>5/25/20 | me Pre | pared:         |
|--|---------|--------------------------------------|--|---------------|-----------|---------|---------------|-------------------------------------|----------------|---|--------|----------------|
| 1.00   Street; Y20 SSUIR SATE SIREET   Y00 BOX;   State I M 71p Coder 47900   County WHITE   2.00   County WHITE   Y00   County WHITE   Y00        |         | 1.00                                 |  | . 00          | 3.        | 00      |               |                                     | 4. 00          |   |        |                |
| Number   N     |         | Street: 720 SOUTH SIXTH STREET       | PO Box:                                | IN Zi         | p Code:   | 47960   | Count         | y: WHITE                            |                |   |        | 1. 00<br>2. 00 |
| Hospitul and Hyapitul-Based Component Literatification:   1.00   |         |                                      | Component N                            |               |           |         |               |                                     | T,             | 0, or                                   | N)     |                |
| Bosgital and Insight   Tall Based Component Identification   Insight   Ins     |         |                                      | 1.00                                   | 2             | 2, 00     | 3. 00   | 4.00          | 5. 00                               |                |   |        | _              |
| 4.00 Subgrovi der - 1PF 5.00 Subgrovi der - 1PF 5.00 Subgrovi der - 1PF 6.00 S   |         | Hospital and Hospital-Based Componer |  |               |           |         |               |                                     | 1 0.00         | 1                                       |        |                |
| Subprovider - IRF   Subp     |         |                                      |  | 15            | 1312      | 99915   | 1             | 07/01/1966                          | N              | 0                                       | 0      | 3. 00          |
| 6.00 Subgrout der - (Other)  1.00 Seing Beds - NF  1.00 File Beds - NF  1.00 Hospital Based NF  1.00 Hospital Based NF  1.00 Hospital Based NF  1.00 Hospital Based NF  1.00 Separatel Based HPA  1.00 Separatel Based HPA  1.00 Separatel Based HPA  1.00 Hospital Based HPA  1.00 HPA  1.00 Hospital Based HPA  1.00    |         | •                                    |  |               |           |         |               |                                     |                |   |        |                |
| 1.00   Saying Beds - SNF   IN HEATH WHITE   152312   99915   02/16/1990   N   0   N   7.00   |         | · ·                                  |  |               |           |         |               |                                     |                |   |        | 6.00           |
| 8.00 Ming Bads - NF 9.00 Hospital-Based SIF 10.00 Hospital-Based WF 11.00 Hospital-Based WF 11.00 Hospital-Based MR 12.00 Hospital-Based MR 13.00 Separately Certified ASC 14.00 Hospital-Based Hospical 14.00 Hospital-Based Hospical 15.00 Hospital-Based Hospical 16.00 Hospital-Based Hospical 16.00 Hospital-Based Hospital Hospical 16.00 Hospital-Based Hospital Hospical 16.00 Hospital-Based Hospital 17.00 Hospital-Based Hospital 18.00 Kenal Dialysis 19.00 Proceeding Period (mm/dd/yyyyy) 19.00 Procedure Procedure 18.00 Renal Dialysis 19.00 Procedure 19.00 Procedure 19.00 Renal Dialysis 19.00 R   |         | 1 .                                  | IU HEALTH WHITE                        | 15            | Z312      | 99915   |               | 02/16/1990                          | N              | 0                                       | N      | 7. 00          |
| 9.00 Mospital-Based NF 11.00 Mospital-Based NF 11.00 Mospital-Based OTC 12.00 Mospital-Based OTC 12.00 Mospital-Based Host NC CARE OF WHITE 157514 99915 03/01/1997 N N 12.00 15.00 Mospital-Based Host RC CINIC - RNC 17.00 Mospital-Based Host RC CINIC - RNC 17.00 Mospital-Based Host RC CINIC - RNC 18.00 Mospital-Based Host RC CINIC - RNC 19.00 Dither - To Control (See Instructions) 19.00 Dots This Facility quality and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter - "" For yes or "N" for no. Is its Facility quality shall be control with the proportionate of the cost reporting period occurring prior to October 1. Enter in column 2, "" For yes or "N" for the portion of the cost reporting period occurring prior to October 1. Enter in column 1, "" For yes or "N" for no. For the portion of the cost reporting period occurring prior to October 1. Enter in column 1, "" For yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 1, "" For yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 1, "" For yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 1, "" For yes or "N" for no for the portion of the cost reporting period on or after October 1. Column 2, "" For yes or "N" for no for the portion of the cost reporting period on or after October 1. Column 2, "" For yes or "N" for no for the portion of the cost reporting period on or after October 1. Column 2, "" For yes or "N" for no for the portion of the cost reporting period on or after October 1. Column 2, "" For yes or "N" for no for the portion of the cost reporting period or or after October 1. Column 2, "" For yes or "N" for no for the portion of the co  |         |                                      | HOSPI TAL                              |               |           |         |               |                                     |                |   |        |                |
| 10.00  |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 11.00  |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 12.00   Despirate   Research HPA   |         | , ·                                  |  |               |           |         |               |                                     |                |   |        | 11.00          |
| 13.00   Separately Certified ASC   14.00   Hospital -Based Health Clinic - RHC   14.00   Hospital -Based Health Clinic - RHC   15.00   16.00     |         |                                      | HOME CARE OF WHI                       | TE 15         | 7514      | 99915   |               | 03/01/1997                          | N              | N                                       | N      | 12.00          |
| 14.00 (hospital-Based Mospice) 15.00 (hospital-Based Health Clinic - RHC 16.00 (hospital-Based Health Clinic - FOHC 17.00 (hospital-Based COMIC) 18.00 (Renal Dialysis) 19.00 (btter) 20.00 (Cost Reporting Period (mm/dd/yyyy) 21.00 (lyge or Control (see Instructions) 22.00 (logital - Based Comic) 22.00 (logital - Based Comic) 23.00 (logital - Based Comic) 24.00 (logital - Based Comic) 25.00 (logital - Based Comic) 26.00 (logital - Based Comic) 27.00 (lyge or Control (see Instructions) 28.00 (logital - Based Comic) 29.00 (logital - Based Health Clinic - Relicitity Subject to 42 CFR Section S412 106(c) (2) (Pickle semendent hospital?) In column 1, enter "V" for yes or "N" for no. Is this facility subject to 42 CFR Section S412 106(c) (2) (Pickle semendent hospital?) In column 2, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section S412 106(c) (2) (Pickle semendent hospital?) In column 2, enter "Y" for yes or "N" for no. In this facility subject to 42 CFR Section S412 106(c) (2) (Pickle semendent hospital?) In column 1, enter "V" for yes or "N" for no. In this facility subject to 42 CFR Section S412 106(c) (2) (Pickle semendent hospital?) In column 2, enter "Y" for yes or "N" for no. In this facility subject to 42 CFR Section S412 106(c) (2) (Pickle semendent hospital?) In column 2, enter "Y" for yes or "N" for no. For the portion of the cost reporting period occurring period occurring period occurring period occurring period occurring period occurring on or after October 1. Enter in column 1, "V" for yes or "N" for no. For the portion of the cost reporting period occurring perio   |         |                                      | COUNTY                                 |               |           |         |               |                                     |                |   |        |                |
| 15.00   Hospital - Based Heal th Clinic - FBRC   16.00   Hospital - Based Heal th Clinic - FGRC   17.00   16.00   Hospital - Based (CMRC)   18.00   Rehall Bial yes   19.00   17.00   19.00      |         | 1 '                                  |  |               |           |         |               |                                     |                |   |        | 13.00          |
| 16.00   hospital - Based (CMHC)   17.00   18.00   18.00   18.00   18.00   19.00    |         | , .                                  |  |               |           |         |               |                                     |                |   |        |                |
| 17.00   Dispital - Based (CMRC)   18.00   Real Dialysis   18.00   Real Dialysis   19.00   Other   18.00   Real Dialysis   19.00   19     |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 18.00 Renal Dialysis   18.00   19.00     |         |                                      |  |               |           |         |               |                                     |                |   |        | 17. 00         |
| 20.00   Cost Reporting Period (mm/dd/yyyy)   |         |                                      |  |               |           |         |               |                                     |                |   |        | 18.00          |
| 20.00 Cost Reporting Period (mm/dd/yyyy) 21.00 Type of Control (see instructions) 17ype of Control (see instructions) 17ype of Control (see instructions) 18ype of Control (see instructions) 19ype of Control (see instructions) 20 00 Does this Facility quality and is it currently receiving payments for disproportionate 19ype of Control (see instructions) 21,00 22,00 22,00 25,00 26,00 27,00 28,00 29,00 29,00 29,00 20,00   | 19. 00  | Other                                |  |               |           |         |               |                                     |                |   |        | 19. 00         |
| 20.00   Cost Reporting Period (mm/dd/yyyy)   20.00   21.00   Typed Control (see instructions)   21.00   Typed or Control (see instructions)   21.00   Typed tent PPS Information   22.00   Does this facility typualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR \$412.1067   In column 1, enter ""   N  |         |                                      |  |               |           |         |               |                                     |                |   |        | -              |
| 2   2   2   2   2   2   2   2   2   2  | 20.00   | Cost Reporting Period (mm/dd/yyyy)   |  |               |           |         |               |                                     |                |   |        | 20.00          |
| 22.00   Does this facility qualify and is it currently receiving payments for disproportionate   N   |         |                                      |  |               |           |         |               | 1                                   | .017           | 12/01/                                  | 2017   | 21.00          |
| share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section \$412.106(c) (2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.  22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see Instructions)  22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost reports estilement? (see Instructions) Enter in column 2, "Y" for yes or "N" for yes or "N" for the portion of the cost reporting period occurring on or after October 1. Enter in column 2, "Y" for yes or "N" for the portion of the cost reporting period on a fitter October 1. The or after Oc |         | Inpatient PPS Information            |  |               |           |         |               |                                     |                |   |        |                |
| for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c) (2) (Pickle amendment hospital 17) In column 2, enter "Y" for yes or "N" for no.  22.01 bid this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after 0ctober 1. (see instructions)  22.02 Is this a newly perged hospital that requires final uncompensated care payments to be determined at cost reporting period occurring on or after 0ctober 1. (see instructions) Enter in column 1, "Y" for yes or "N" for the portion of the cost reporting period or 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after 0ctober 1.  22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by OMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period or to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after 0ctober 1. (see instructions) Does this hospital contain at least 100 but not more than 409 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on 1 lines 24 and/or 25 below? In column 4, 11 and 11 fatte of admission, 2 if census days, or 3 if date of discharge. Is the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 Which method is used to determine Medicaid days on 1 lines 24 and/or 25 below? In column 4, Medicaid days and admission of the method is unpaid days on column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRP, enter the in-state Medicaid eligible u   | 22. 00  |                                      |  |               |           |         |               | N                                   |                | N                                       |        | 22. 00         |
| amendment hospital?) In column 2, enter "Y" for yes or "N" for no.  22.01 Did this hospital receive interial uncompensated care payments for this cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no. for the portion of the cost reporting period occurring on or after October 1. Enter in column 2, "Y" for yes or "N" for no. for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no. for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no. for the portion of the cost reporting period on or after October 1. Enter in column 1, "Y" for yes or "N" for no. for the portion of the cost reporting period on or after October 1. Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no.  22.03  23.00 Which method is used to determine Medic aid days on Inless 24 and/or 25 below? In column 2, enter "Y" for yes or "N" for no.  24.00 Which method is used to determine Medic aid days on Inless 24 and/or 25 below? In column 3 and the portion of the cost reporting period of different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  25.00 Which method is used to determine Medic aid days on Inless 24 and/or 25 below? In column 4 and aid days and and eligible unpaid days in column 1, In-state Medic aid plated days in column 2, enter "Y" for yes or "N" for no.  26.00 If this provider is an IRF, enter the in-state Medicaid beligible unpaid days in column 3, out-of-state Medicaid beligible unpai   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 22.01 bid this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)  22.02 Is this a newly werged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period or or after October 1. Enter in column 2, "V" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Enter in column 2, "V" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Enter in column 2, "V" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Enter in column 1, "V" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Enter in column 1, "V" for yes or "N" for no for the portion of the cost reporting period or prior to October 1. Enter in column 1, "V" for yes or "N" for   |         | amendment hospital?) In column 2 en  | ity Subject to 4.<br>Her "V" for ves ( | 2 CFR Section | DN 9412.  | 106(0)( | .2) (PI CKI 6 | 9                                   |                |   |        |                |
| period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring period occurring on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)  22. 02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost reports test iment? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period on or after October 1. Standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period on prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period on prior to October 1. Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period on prior to October 1. Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period on prior to October 1. Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period on or after October 1. (see instructions) Does this hospital at a tleast 100 but not more than 499 beds (as counted in accordance with 42 CPR 412, 105)? Enter in column 3, "Y" for yes or "N" for no.  23. 00 Which method is used to determine Medicaid days in fine s24 and/or 25 below? In column 3 if date of discharge. Is the method of identifying the days in the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24. 00 If this provider is an IPPS hospital, enter the in-state Medicaid days in co   | 22. 01  |                                      |  |               |           | cost re | porting       | N                                   |                | N                                       |        | 22. 01         |
| for no for the portion of the cost reporting period occurring on or after October 1.  (see instructions)  22. 02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1.  22. 03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on Il ines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method or identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the lin-state Medicaid and adjad days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid and side and days in column 3, out-of-state Medicaid and side and adjad sin column 3, out-of-state Medicaid and side unpaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 4, Medicaid eligible unpaid da   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| (see instructions)  22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.  22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period caused in the prior column 3, "Y" for yes or "N" for no for the portion of the cost reporting period different from the method is used to determine Medicaid days on Ilnes 24 and/or 25 below? In column 3 N 23.00 and 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid and paid days in column 1, in-state Medicaid paid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid deligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4,   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 22.02 is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "V" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.  22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "V" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 4. enter 11f date of admission, 2 If census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid paid days in column 3, out-of-state Medicaid day in an incolumn 3, incolumn 5, and other Medicaid days in column 3, out-of-state Me   |         |                                      | reporting period (                     | occurri ng o  | n or aft  | er Octo | ber 1.        |                                     |                |   |        |                |
| determined at cost report settlement? (See Instructions) Enter in column 1, "" for yes or "N" for no, for the portion of the cost reporting period or in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.  22. 03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23. 00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 with method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24. 00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 6.  25. 00 If this provider is an IRP, enter the in-state Medicaid eligible unpaid days in column 6.  25. 00 If this provider is an IRP, enter the in-state Medicaid eligible unpaid days in column 6.  26. 00 If this provider is an IRP, enter the in-state Medicaid eligible unpaid days in column 7, unto first the Medicaid eligible unpaid days in column 8.  26. 00 If this provider is an IRP, enter the in-state Medicaid eligible unpaid days in column 1, in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medica   | 22 02   |                                      | requires final :                       | uncompensati  | ed care   | navment | s to be       | N                                   |                | N                                       |        | 22 02          |
| or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.  22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no. The portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method paid days in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the Medicaid day in column 3, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid days in column 1, the in-state Medicaid days in column 1, the in-state Medicaid days in column 4, Medicaid Medicaid days in column 4, Medicaid days in column 5, and the method by   | 22.02   |                                      |  |               |           |         |               |                                     |                |   |        | 22.02          |
| or after October 1.  22.03 Id this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 bellow? In column 1, inter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the Medicaid deligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid  |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period oprior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid aligible unpaid days in column 1, medicaid days in column 2, out-of-state Medicaid apid days in column 3, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid days in column 1, the in-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid eligible unpaid days in column 3, out-of-state Medicaid paid days in column 4, Medicaid Medicaid eligible unpaid days in column 3, out-of-state Medicaid paid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in c   |         |                                      | no, for the porti                      | ion of the    | cost rep  | orting  | period or     | ו                                   |                |   |        |                |
| of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted to the prior cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted to the prior cost reporting or yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "V" for yes or "N" for no.  In-State Medicaid bedicaid and days in column 1, in-state Medicaid bedicaid and bedicaid and days in column 1, in-state Medicaid and days in column 2, out-of-state Medicaid and eligible unpaid days in column 3, out-of-state Medicaid and eligible unpaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid and days in column 3, out-of-state Medicaid and days in column 4, Medicaid eligible unpaid days in column 2, out-of-state Medicaid and days in column 3, out-of-state Medicaid and days in column 4, Medicaid eligible unpaid days in column 2, out-of-state Medicaid and days in column 3, out-of-state Medicaid and days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 3, out-of-state Medicaid and days in column 4, Medicaid eligible unpaid days in column 5, and there in the in-state Medica   | 22. 03  |                                      |  |               |           |         |               | t N                                 |                | N                                       |        | 22. 03         |
| prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  In-State Medicaid and all prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  1.00 2.00 3.00 4.00 5.00 6.00  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid paid days in column 3, out-of-state Medicaid paid days in column 3, out-of-state Medicaid paid days in column 4, Medicaid paid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid Me   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State Medicaid and the method of adays in column 1, in-state with method of identifying the days in column 1, enter the in-state Medicaid and adays in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 6.   In-State Wedicaid and eligible unpaid days in column 1, in-state Medicaid eligible unpaid days in column 6. In-state Medicaid eligible unpaid days in column 7, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 5, out-of-state Me   |         |                                      |  |               |           |         |               | 9                                   |                |   |        |                |
| 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In -State     |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid   |         |                                      |  |               | unted in  | accord  | lance with    | וי                                  |                |   |        |                |
| 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid   Me   | 22 00   |                                      |  |               | /or 25 h  | olow2 I | n column      |                                     | 2              | N                                       |        | 22 00          |
| method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid     | 23.00   |                                      |  |               |           |         |               |                                     | ٦              | 11                                      |        | 23.00          |
| In-State Medicaid paid days and the medicaid paid days in column 1, the in-state Medicaid days in column 2, out-of-state Medicaid days in column 6.  25. 00 If this provider is an IRF, enter the in-state Medicaid days in column 1, the in-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 6.  25. 00 If this provider is an IRF, enter the in-state Medicaid days in column 1, the in-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 6.  25. 00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 5, and the medicaid eligible unpaid days in column 6.  |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| Medicaid paid days  1.00  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 3, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid paid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in colum   |         | used in the prior cost reporting per | iod? In column :                       |               |           |         |               |                                     |                |   |        |                |
| paid days eligible unpaid eli   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| 24.00 If this provider is an IPPS hospital, enter the in-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IPPS hospital, enter the olin-state Medicaid eligible unpaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 1, in-state Medicaid eligible unpaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid  |         |                                      |  |               |           |         |               |                                     | nwo uay        |   |        |                |
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| 24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid  |         |                                      |  |               | days      |         |               | unpai d                             |                |   |        |                |
| in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid  | 0:      | 16.00                                |  |               | 2. 00     |         |               |                                     | 5. 00          |   |        | 0              |
| Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid   | 24. 00  | · ·                                  |  | 0             |           | O       | O             | O                                   |                | o                                       | 0      | 24.00          |
| out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid  Medicaid eligible unpaid days in column 4, Medicaid   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid  |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state  Medicaid paid days in column 1, the in-state  Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state  Medicaid eligible unpaid days in column 4, Medicaid   |         | out-of-state Medicaid eligible unpai | d days in column                       |               |           |         |               |                                     |                |   |        |                |
| 25.00 If this provider is an IRF, enter the in-state  Medicaid paid days in column 1, the in-state  Medicaid eligible unpaid days in column 2,  out-of-state Medicaid days in column 3, out-of-state  Medicaid eligible unpaid days in column 4, Medicaid  |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
| Medicaid paid days in column 1, the in-state  Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state  Medicaid eligible unpaid days in column 4, Medicaid   | 25 00   |                                      |  |               |           |         |               |                                     |                |   |        | 25 00          |
| Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid  | ∠5.00   |                                      |  |               |           | ٥       | ٥             | U                                   |                | ۷                                       |        | 25.00          |
| out-of-state Medicaid days in column 3, out-of-state<br>Medicaid eligible unpaid days in column 4, Medicaid  |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
|  |         | out-of-state Medicaid days in column | 3, out-of-state                        |               |           |         |               |                                     |                |   |        |                |
| HMO paid and eligible but unpaid days in column 5.   |         |                                      |  |               |           |         |               |                                     |                |   |        |                |
|  |         | HMU paid and eligible but unpaid day | rs in column 5.                        | <u> </u>      | <u> </u>  |         |               |                                     |                |   |        | <u> </u>       |

instructions)

| Health Financial Systems IU HE<br>HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION   |  | Provider C  | CN: 15-1312                 | Peri od:                         | eu of Form CMS-2<br>Worksheet S-2 |        |
|--|--|---|-----------------------------|----------------------------------|-----------------------------------|--------|
| INSTITUTE THE HEALTH SINCE SOME LEX TREATH TO ATTOM  |  | Trovider of   |                             | From 01/01/2017<br>To 12/31/2017 | Part I                            | pared: |
|  | Y/N  | IME   | Direct GME                  | IME                              | Direct GME                        |        |
|  | 1. 00  | 2. 00   | 3. 00                       | 4.00                             | 5. 00                             |        |
| \$1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). \$1.05 Enter the difference between the baseline primary  |  |   |                             |                                  |                                   | 61. 0  |
| 1.05 Enter the difference between the baseline primary<br>and/or general surgery FTEs and the current year's<br>primary care and/or general surgery FTE counts (lir<br>61.04 minus line 61.03). (see instructions)   | ie   |   |                             |                                  |                                   | 61.0   |
| 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)   |  | ogram Name  | Program Code                |                                  |                                   | 61.0   |
|  | e Unweighted IME<br>FTE Count                                  | Unweighted Direct GME FTE Count                       |                             |                                  |                                   |        |
| 4 40 log 11 - 575 1 - 11 - 14 - 5  |  | 1. 00   | 2. 00                       | 3.00                             | 4.00                              |        |
| 51.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.     |  |   |                             | 0.00                             | 0.00                              | 61. 10 |
| of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. |  |   |                             | 0. 00                            | 0. 00                             | 61. 20 |
|  |  |   |                             |                                  | 1.00                              |        |
| ACA Provisions Affecting the Health Resources and S  | Services A   | Admi ni strati on                                     | (HRSA)                      |                                  | 1.00                              |        |
| 2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instr  | ıl trai ned  |   |                             | riod for which                   | 0.00                              | 62. 0  |
| 2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pr Teaching Hospitals that Claim Residents in Nonprovi   | n a Teachi<br>rogram. (s                                       | see instructio  |                             | o your hospital                  | 0.00                              | 62. 0  |
| 3.00 Has your facility trained residents in nonprovider "Y" for yes or "N" for no in column 1. If yes, comp  | settings   | during this co  |                             |                                  | N                                 | 63. 0  |
| 1 101 yes of 11 101 110 111 condamin 11 11 yes of comp   |  | or em ough  | Unwei ghted                 | Unwei ghted                      | Ratio (col. 1/                    |        |
|  |  |   | FTEs<br>Nonprovider<br>Site | FTEs in<br>Hospital              | (col. 1 + col.<br>2))             |        |
| Section EEOA of the ACA Dage Veen FTF Decidents in   | Nonnes d'  | dor Cottings  | 1. 00                       | 2.00                             | 3. 00                             |        |
| Section 5504 of the ACA Base Year FTE Residents in period that begins on or after July 1, 2009 and bet   | Fore June  | 30, 2010.   | illis base yea              | i is your cost i                 | epor tring                        |        |
| 4.00 Enter in column 1, if line 63 is yes, or your facil in the base year period, the number of unweighted resident FTEs attributable to rotations occurring i settings. Enter in column 2 the number of unweight resident FTEs that trained in your hospital. Enter of (column 1 divided by (column 1 + column 2)). (see                    | ity train<br>non-primar<br>n all non<br>ed non-pr<br>in column | ned residents ry care riprovider rimary care rimation | 0. (                        | 0.00                             | 0. 000000                         | 64.0   |
| Program Name   |  | ogram Code  | Unwei ghted                 | Unwei ghted                      | Ratio (col. 3/                    |        |
|  |  |   | FTEs<br>Nonprovider<br>Site | FTEs in                          | (col. 3 + col.<br>4))             |        |
| 1 00   |  | 2 00  | 3.00                        | 4 00                             | 5.00                              | i      |

2.00

4.00

3. 00

5.00

1.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1312 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 5: 20 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

| IOSPI TAI  | inancial Systems IU HEALTH WHIT<br>AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA   | Provi der CC    | CN: 15-1312   | Peri od:<br>From 01/01/2017<br>To 12/31/2017 | u of Form CMS-<br>Worksheet S-2<br>Part I<br>Date/Time Pre | 2                |
|--|---|-----------------|---------------|--|--|------------------|
|  |   |                 |               |  | 5/25/2018 5: 2   | 20 pm            |
|  | ong Term Care Hospital PPS  |                 |               |  | 1. 00  |                  |
| 30. 00 I<br>31. 00 I   | s this a long term care hospital (LTCH)? Enter "Y" for yes<br>s this a LTCH co-located within another hospital for part c<br>Y" for yes and "N" for no.                           |                 |               | g period? Enter                              | N<br>N   | 80. 00<br>81. 00 |
| 5. 00 I<br>6. 00 D   | EFRA Providers s this a new hospital under 42 CFR Section §413.40(f)(1)(i) id this facility establish a new Other subprovider (exclude  |                 |               |  | N  | 85. 00<br>86. 00 |
| 7. 00 I  | 413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. s this hospital an extended neoplastic disease care hospita  984(d)(1)(P)(y)? Enter "Y" for yes or "N" for no.                | ıl classified ι | under section |  | N  | 87. 0            |
|  | 886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.  |                 |               | V  | XI X   |                  |
|  |   |                 |               | 1. 00  | 2.00   |                  |
| _  | itle V and XIX Services   |                 |               |  |  |                  |
|  | oes this facility have title V and/or XIX inpatient hospita<br>es or "N" for no in the applicable column.   | al services? Er | nter "Y" for  | N  | Y  | 90.0             |
|  | s this hospital reimbursed for title V and/or XIX through t   | he cost report  | t either in   | N  | N  | 91.0             |
|  | ull or in part? Enter "Y" for yes or "N" for no in the appl   |                 |               |  | N  | 92. 0            |
|  | re title XIX NF patients occupying title XVIII SNF beds (du<br>nstructions) Enter "Y" for yes or "N" for no in the applica  |                 | on)? (see     |  | IN IN  | 92.0             |
| 3.00 D   | oes this facility operate an ICF/IID facility for purposes  |                 | d XIX? Enter  | N  | N  | 93. 0            |
| 4. 00 D  | Y" for yes or "N" for no in the applicable column. oes title V or XIX reduce capital cost? Enter "Y" for yes,   | and "N" for no  | o in the      | N  | N  | 94. 0            |
|  | pplicable column.<br>fline 94 is "Y", enter the reduction percentage in the app   | olicable column | ٦.            | 0. 00  | 0.00   | 95.0             |
| 6. 00 D  | oes title V or XIX reduce operating cost? Enter "Y" for yes   |                 |               | N  | N  | 96.0             |
| 1  | pplicable column.<br>fline 96 is "Y", enter the reduction percentage in the app   | olicable column | n             | 0.00   | 0.00   | 97.0             |
| 8.00 D<br>s  | oes title V or XIX follow Medicare (title XVIII) for the in<br>tepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f<br>olumn 1 for title V, and in column 2 for title XIX. | nterns and resi | dents post    | N  | Y  | 98. 0            |
| 3. 01 D<br>C   | oes title V or XIX follow Medicare (title XVIII) for the re<br>, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti<br>itle XIX.   |                 |               |  | Y  | 98. 0            |
| 8. 02 D  | oes title V or XIX follow Medicare (title XVIII) for the ca<br>ed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o<br>or title V, and in column 2 for title XIX.          |                 |               | N  | Y  | 98. 0            |
| 3.03 D<br>r  | oes title V or XIX follow Medicare (title XVIII) for a crit<br>eimbursed 101% of inpatient services cost? Enter "Y" for ye  |                 |               |  | N  | 98. 0            |
| 8. 04 D<br>o   | or title V, and in column 2 for title XIX. oes title V or XIX follow Medicare (title XVIII) for a CAH utpatient services cost? Enter "Y" for yes or "N" for no in                 |                 |               | N  | N  | 98. 0            |
| 8. 05 D<br>W   | n column 2 for title XIX.<br>oes title V or XIX follow Medicare (title XVIII) and add ba<br>kst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c<br>olumn 2 for title XIX. |                 |               |  | Y  | 98. 0            |
| 8. 06 D<br>P   | ocestitle V or XIX.  oes title V or XIX follow Medicare (title XVIII) when cost ts. I through IV? Enter "Y" for yes or "N" for no in column olumn 2 for title XIX.                |                 |               | N  | Y  | 98. 0            |
|  | ural Providers  |                 |               |  |  |                  |
|  | oes this hospital qualify as a CAH?   |                 |               | . Y  |  | 105. 0           |
| 06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  |   |                 |               |  |  | 106. 0           |
| 07.00 f this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. |   |                 |               |  | 107. C   |                  |
| 00 .8C   | s this a rural hospital qualifying for an exception to the FR Section §412.113(c). Enter "Y" for yes or "N" for no.   | CRNA fee sched  | dul e? See 42 | N  |  | 108. 0           |
|  | 1 101 yes of N 101 110.   | Physi cal       | Occupati ona  | I Speech                                     | Respi ratory   |                  |
|  |   | 1.00            | 2.00          | 3.00   | 4.00   |                  |
| no noli  | f this hospital qualifies as a CAH or a cost provider, are  | N               | N             | N  | N  | 109.00           |
|  | herapy services provided by outside supplier? Enter "Y"   |                 |               |  |  |                  |

|   | 1.00 |         |
|---|------|---------|
| 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A | N    | 110. 00 |
| Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,     |      |         |
| complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as |      |         |
| appl i cabl e.  |      |         |

| IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Provider CCN: 15-1312  | Period:<br>From 01/01/2<br>To 12/31/2 |              | Prepared: |
|--|--|---------------------------------------|--------------|-----------|
|  |  | 1. 00                                 | 2.00         |           |
| 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.  | st reporting period? Ente<br>umn 1 is Y, enter the<br>ticipating in column 2.      | N                                     | 2.00         | 111.00    |
|  |  |                                       | 1.00 2.00 3. | 00        |
| Miscellaneous Cost Reporting Information  15.00 sthis an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208. 1.  16.00 sthis facility classified as a referral center? Enter "Y" for yes or is yes. | If column 2 is "E", ente<br>t for long term care (inc<br>s) based on the definitio | r in column<br>ludes                  | N (          | 115. 00   |
| 17.00 s this facility legally-required to carry malpractice insura   |  | r "N" for                             | N            | 117. 00   |
| 18.00 is the mal practice insurance a claims-made or occurrence policial m-made. Enter 2 if the policy is occurrence.  | cy? Enter 1 if the polic   | y is                                  | 1            | 118. 00   |
|  | Premi ums  | Losses                                | Insurance    | е         |
|  | 1.00   | 2.00                                  | 3.00         |           |
| 18.01 List amounts of malpractice premiums and paid losses:  | 39,  | 554                                   | 0            | 0 118. 0  |
|  |  | 1.00                                  | 2.00         |           |
| 18.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE   |  | N                                     |              | 118. 02   |
| 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.   | column 1, "Y" for yes or<br>alifies for the Outpatien                              |                                       | N            | 120.00    |
| 21.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.   | ntable devices charged to  | Y                                     |              | 121. 0    |
| 22.00 Does the cost report contain healthcare related taxes as defi<br>Act?Enter "Y" for yes or "N" for no in column 1. If column 1<br>the Worksheet A line number where these taxes are included.   |  |                                       | 5. 00        | 122. 0    |
| Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for  | yes and "N" for no. If   | N                                     |              | 125. 0    |
| yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 of this is a Medicare certified kidney transplant center, ent  |  | е                                     |              | 126. 0    |
| in column 1 and termination date, if applicable, in column 2.  27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.  | er the certification date  |                                       |              | 127. 0    |
| 28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.   | er the certification date  |                                       |              | 128. 0    |
| 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.   |  | in                                    |              | 129. 0    |
| 30.00 If this is a Medicare certified pancreas transplant center, edate in column 1 and termination date, if applicable, in column 1.  | umn 2.   |                                       |              | 130. 0    |
| 31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column  | umn 2.   |                                       |              | 131. 00   |
| 32.00  f this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.   |  |                                       |              | 132. 00   |
| 33.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the   |  |                                       |              | 133. 00   |
| and termination date, if applicable, in column 2.  All Providers   | 3 3. 3 Hamber 111 COT and 1  |                                       |              |           |
| 40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y  |  | y<br>s                                | 15H059       | 140. 00   |

Health Financial Systems IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1312 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/25/2018 5:20 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: INDIANA UNIVERSITY HEALTH | Contractor's Name: WPS 141. 00 Name: INDIANA UNIVERSITY HEALTH Contractor's Number: 08101 141 00 142.00 Street: 340 WEST 10TH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS State: Zip Code: 46202 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 11/22/2017 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 Ν Ν 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 5.00 0 1.00 2.00 3.00 4.00 166.00 If line 165 is yes, for each 0. 00 166. 00

|   |                | 1.00       |         |
|---|----------------|------------|---------|
| Health Information Technology (HIT) incentive in the American Recovery and Reinvestment         | Act            |            |         |
| 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.      |                | Υ          | 167. 00 |
| 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),  | enter the      | (          | 168. 00 |
| reasonable cost incurred for the HIT assets (see instructions)                                  |                |            |         |
| 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a | hardshi p      |            | 168. 01 |
| exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)          |                |            |         |
| 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N | l"), enter the | 0.00       | 169. 00 |
| transition factor. (see instructions)   |                |            |         |
|   | Begi nni ng    | Endi ng    |         |
|   | 1. 00          | 2. 00      |         |
| 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting        | 04/01/2017     | 06/30/2017 | 170. 00 |
| period respectively (mm/dd/yyyy)  |                |            |         |
|   |                |            |         |
|   | 1. 00          | 2.00       |         |
| 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in         | Y              | 59         | 7171.00 |
| section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter            |                |            |         |
| "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section         |                |            |         |
| 1876 Medicare days in column 2. (see instructions)  |                |            |         |
|   |                |            |         |
|   |                |            |         |

campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

N

19.00

N

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

information? If yes, see instructions.

19.00

| Description   Y/N   Y/N   Q   1.00   3.00   3.00   3.00   4.00   1.00   3.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00    | CMS-2552-10                   |
|--|-------------------------------|
| 20.00   If line 16 or 17 is yes, were adjustments made to PSAR Report data for Other? Describe the other adjustments:    1.00  | S-2<br>Prepared:<br>S 5:20 pm |
| Report data for Other? Describe the other adjustments:   Y/N   Date   Date   Date   Y/N   Date   Date   Date   Y/N   Date   Date   Date   Y/N   Date   Date   Date   Date   Y/N   Date   D   |                               |
| Report data for Other? Describe the other adjustments:   | 20. 00                        |
| 1.00   2.00   3.00   4.00  | 20.00                         |
| 21.00   Was the cost report prepared only using the provider's   N   N   |                               |
| COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)   Capital Related Cost  |                               |
| COMPLETED BY COST REIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)  Capital Related Cost  22.00 Have assets been relifed for Medicare purposes? If yes, see instructions  83.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.  84.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Note that the provider see instructions.  85.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  86.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  87.00 Have new leases, subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  88.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit not copy.  89.00 Interest Expense  80.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions in the period of the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Not treated as a funded depreciation account? If yes, see instructions.  80.00 Have provider have a funded depreciation account? If yes, see instructions.  81.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see Instructions.  81.00 Have changes or new agreements occurred in patient care services furnished through competitive bidding? If no. see Instructions.  82.00 Were home office costs claimed on the cost report?  83.00 If line 32 is yes, were there new agreements or amended existing agreements with the provider-based No physicians during the cost reporting period? If yes, see instructions.  84.00 Were home office costs claimed on the cost report?  85.00 If line 36 is yes, has a home of | 21. 00                        |
| COMPLETED BY COST REIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)   Capital Related Cost  |                               |
| 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.  24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.  25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Instructions.  26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions.  27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  27.00 Las the provider's capitalization policy changed during the cost reporting period? If yes, submit to copy.  28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  30.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  30.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  30.00 Has debt been recalled before scheduled maturity without instructions.  30.00 Formulations arrangements with suppliers of services? If yes, see instructions.  30.00 Formulations arrangements with suppliers of services? If yes, see instructions.  30.00 Formulations are the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  30.00 Formulation are the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  4.00 Formulation are the provider remover services to the home office?  4.00 F |                               |
| 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.  24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions  25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  27.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  28.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit copy.  28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  32.00 Has debt seen replaced prior to its scheduled maturity without issuance of new debt? If yes, see instructions.  33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  34.00 Are services furnished at the provider facility under an arrangement with the provider-based physicians?  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians our introductions.  36.00 Were home office costs  40.00 Home office costs  40.00 Were home office costs statement been prepared by the home office?  41.00 2.00 Home office costs  42.00 Has debt been replaced provider render services to the home office? If yes, see instructions.      |                               |
| reporting period? If yes, see instructions.  25.00 Have there been new capitalized leases entered into during this cost reporting period? If yes, see instructions  26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  17.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  18.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit copy.  18.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 If the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Not treated as a funded depreciation account? If yes, see instructions  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions.  32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32.00 Hilling 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  33.00 Froider-Based Physicians  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  40.01 Filing 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians of If yes, see instructions.  34.00 Froider-Based Physicians  35.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  37.00 If line 36 is yes, was the fiscal year end of the home office?  3 | 22. 00                        |
| 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?  If yes, see instructions.  25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  Interest Expense  28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions.  32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  33.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians?  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  35.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  37.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider render services to other chain components? If yes, see instructions.  36.00 Were home office costs claimed on the cost report?  37.01 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  | 23. 00                        |
| 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions.  27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Not treated as a funded depreciation account? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions.  32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32.00 If Iline 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Nonlysicians and physicians are serviced for the cost reporting period? If yes, see instructions.  36.00 Were home office costs claimed on the cost report?  37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of Nother provider Pity yes, see instructions.  38.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  | 24. 00                        |
| instructions.  Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions.  7.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  Interest Expense  8.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  9.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions  10.00 Has debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  10.01 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  10.02 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  10.03 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  10.04 Purchased Services  10.05 Purchased Services  10.06 Purchased Services  10.07 Purchased Services  10.08 Purchased Physicians  10.09 Purchased Purchased at the provider facility under an arrangement with provider-based physicians?  10.09 Purchased Purchased at the provider facility under an arrangement with provider-based physicians?  10.09 Purchased Physicians  10.09 Purchased Purchased Purcha | 25. 00                        |
| Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions.   | 25.00                         |
| Ras the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.   Interest Expense   | 26. 00                        |
| Interest Expense Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  Purchased Services  432.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.  40.00 Were home office Costs  1.00 2.00  Home Office Costs  1.00 2.00  Home office Costs  1.10 2.00  Home office Costs  1.10 2.00  Home office Costs was the fiscal year end of the home office different from that of the provider? If yes, see instructions.  1.11 In 36 is yes, has a home office cost statement been prepared by the home office.  3.10 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  | 27. 00                        |
| 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions.  Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  Provider-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  If yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.  Home Office Costs  40.00 Were home office costs claimed on the cost report?  37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  Y If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  |                               |
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| 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  Provider-Based Physicians  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.    No  | 29. 00                        |
| All the content of the provider of the provi   | 30. 00                        |
| Purchased Services  32. 00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33. 00 If line 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If no, see instructions.  Provider-Based Physicians  34. 00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  35. 00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Nephysicians during the cost reporting period? If yes, see instructions.    Y/N  | 31. 00                        |
| 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  Provider-Based Physicians  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N physicians during the cost reporting period? If yes, see instructions.    Home Office Costs   |                               |
| 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  Provider-Based Physicians  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  Y If yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N physicians during the cost reporting period? If yes, see instructions.  Y/N Date  1.00 2.00  Home Office Costs  Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.   | 32. 00                        |
| Provider-Based Physicians  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  If yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.  Y/N Date  1.00 2.00  Home Office Costs  Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If line 36 is yes, was the fiscal year end of the home office.  38.00 If line 36 is yes, enter in column 2 the fiscal year end of the home office.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.   | 33. 00                        |
| Are services furnished at the provider facility under an arrangement with provider-based physicians?  If yes, see instructions.  If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.    Y/N   Date  |                               |
| If yes, see instructions.  If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.    Home Office Costs   | 34.00                         |
| physicians during the cost reporting period? If yes, see instructions.    Y/N   Date   | 35. 00                        |
| Home Office Costs  36.00 Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  Instructions.  | 35.00                         |
| Home Office Costs  36.00 Were home office costs claimed on the cost report?  37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.   |                               |
| 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  N  Instructions.  |                               |
| If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.   | 36. 00                        |
| 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.  | 37. 00                        |
| 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.  | 38. 00                        |
| 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.  | 39. 00                        |
|  | 40. 00                        |
| 4.00   |                               |
| 1.00 2.00  |                               |
| Cost Report Preparer Contact Information   |                               |
| 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,  | 41. 00                        |
| respectively. 42.00 Enter the employer/company name of the cost report INDIANA UNIVERSITY HEALTH   | 42. 00                        |
| preparer.  | 40.00                         |
| 43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.  RUTTER@IUHEALTH.ORG  | 43. 00                        |

| Heal th | Financial Systems IU HEALTH WH                           | ITE HOSPITAL               | In Lie                      | u of Form CMS-2          | 2552-10        |
|---------|--|----------------------------|-----------------------------|--------------------------|----------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provider CCN: 15-1312      | Peri od:<br>From 01/01/2017 | Worksheet S-2<br>Part II |                |
|         |  |                            | To 12/31/2017               |                          | oared:<br>D pm |
|         |  |                            |                             |                          |                |
|         |  | 3. 00                      |                             |                          |                |
|         | Cost Report Preparer Contact Information                 |                            |                             |                          |                |
| 41.00   | Enter the first name, last name and the title/position   | GOVERNMENT PROGRAMS DIRECT | OR                          |                          | 41.00          |
|         | held by the cost report preparer in columns 1, 2, and 3, |                            |                             |                          |                |
|         | respectively.  |                            |                             |                          |                |
| 42.00   | Enter the employer/company name of the cost report       |                            |                             |                          | 42.00          |
|         | preparer.  |                            |                             |                          |                |
| 43.00   | Enter the telephone number and email address of the cost |                            |                             |                          | 43.00          |
|         | report preparer in columns 1 and 2, respectively.        |                            |                             |                          |                |

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: |

|                  |  |             |     |         | '            | 0 12/31/2017 | 5/25/2018 5: 20 |                  |
|------------------|--|-------------|-----|---------|--------------|--------------|-----------------|------------------|
|                  |  |             |     |         |              |              | I/P Days / O/P  |                  |
|                  |  |             |     |         |              |              | Visits / Trips  |                  |
|                  | Component                                    | Worksheet A | No. | of Beds | Bed Days     | CAH Hours    | Title V         |                  |
|                  | '  | Line Number |     |         | Avai I abl e |              |                 |                  |
|                  |  | 1.00        |     | 2.00    | 3.00         | 4. 00        | 5. 00           |                  |
| 1.00             | Hospital Adults & Peds. (columns 5, 6, 7 and | 30. 00      |     | 25      | 9, 125       | 34, 248. 00  | 0               | 1. 00            |
|                  | 8 exclude Swing Bed, Observation Bed and     |             |     |         |              |              |                 |                  |
|                  | Hospice days) (see instructions for col. 2   |             |     |         |              |              |                 |                  |
|                  | for the portion of LDP room available beds)  |             |     |         |              |              |                 |                  |
| 2.00             | HMO and other (see instructions)             |             |     |         |              |              |                 | 2. 00            |
| 3.00             | HMO IPF Subprovider                          |             |     |         |              |              |                 | 3. 00            |
| 4.00             | HMO IRF Subprovider                          |             |     |         |              |              |                 | 4. 00            |
| 5.00             | Hospital Adults & Peds. Swing Bed SNF        |             |     |         |              |              | 0               | 5. 00            |
| 6.00             | Hospital Adults & Peds. Swing Bed NF         |             |     |         |              |              | 0               | 6. 00            |
| 7.00             | Total Adults and Peds. (exclude observation  |             |     | 25      | 9, 125       | 34, 248. 00  | 0               | 7. 00            |
|                  | beds) (see instructions)                     |             |     |         |              |              |                 |                  |
| 8. 00            | I NTENSI VE CARE UNIT                        | 31. 00      |     | C       | C            | 0.00         | 0               | 8. 00            |
| 9.00             | CORONARY CARE UNIT                           |             |     |         |              |              |                 | 9. 00            |
| 10.00            | BURN INTENSIVE CARE UNIT                     |             |     |         |              |              |                 | 10.00            |
| 11.00            | SURGICAL INTENSIVE CARE UNIT                 |             |     |         |              |              |                 | 11.00            |
| 12.00            | OTHER SPECIAL CARE (SPECIFY)                 | 40.00       |     |         |              |              |                 | 12.00            |
| 13.00            | NURSERY                                      | 43. 00      |     | 0.5     |              |              | 0               | 13.00            |
| 14.00            | Total (see instructions)                     |             |     | 25      | 9, 125       | 34, 248. 00  |                 | 14.00            |
| 15.00            | CAH visits                                   |             |     |         |              |              | 0               | 15. 00           |
| 16.00            | SUBPROVI DER - I PF                          |             |     |         |              |              |                 | 16.00            |
| 17. 00           | SUBPROVIDER - I RF                           |             |     |         |              |              |                 | 17. 00           |
| 18.00            | SUBPROVI DER                                 |             |     |         |              |              |                 | 18.00            |
| 19. 00<br>20. 00 | SKILLED NURSING FACILITY                     |             |     |         |              |              |                 | 19. 00<br>20. 00 |
|                  | NURSING FACILITY                             |             |     |         |              |              |                 |                  |
| 21. 00           | OTHER LONG TERM CARE                         | 101 00      |     |         |              |              | 0               | 21. 00           |
| 22. 00           | HOME HEALTH AGENCY                           | 101. 00     |     |         |              |              | 0               | 22. 00           |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P. )          |             |     |         |              |              |                 | 23. 00<br>24. 00 |
| 24. 00<br>24. 10 | HOSPICE HOSPICE (non-distinct part)          | 30. 00      |     |         |              |              |                 | 24. 00           |
| 25. 00           | CMHC - CMHC                                  | 30.00       |     |         |              |              |                 | 25. 00           |
| 26. 00           | RURAL HEALTH CLINIC                          |             |     |         |              |              |                 | 26. 00           |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER            | 89. 00      |     |         |              |              | 0               | 26. 25           |
| 27. 00           | Total (sum of lines 14-26)                   | 07.00       |     | 25      |              |              |                 | 27. 00           |
| 28. 00           | Observation Bed Days                         |             |     | 20      | '            |              | 0               | 28. 00           |
| 29. 00           | Ambulance Trips                              |             |     |         |              |              |                 | 29. 00           |
| 30. 00           | Employee discount days (see instruction)     |             |     |         |              |              |                 | 30. 00           |
| 31. 00           | Employee discount days (see l'instruction)   |             |     |         |              |              |                 | 31. 00           |
| 32. 00           | Labor & delivery days (see instructions)     |             |     | (       |              |              |                 | 32. 00           |
| 32. 00           | Total ancillary labor & delivery room        |             |     | C       | 1            | ΄            |                 | 32. 00           |
| 32. UI           | outpatient days (see instructions)           |             |     |         |              |              |                 | 32.01            |
| 33. 00           | LTCH non-covered days                        |             |     |         |              |              |                 | 33. 00           |
|                  | LTCH site neutral days and discharges        |             |     |         |              |              |                 | 33. 01           |
| 55. 01           | 121011 31 to floati ai days and ai sonai ges |             | ı   |         | 1            | 1            | 1               | 33.01            |

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: |

|                  |  |             |              | '         | 0 12/31/201/  | 5/25/2018 5: 2 |          |
|------------------|--|-------------|--------------|-----------|---------------|----------------|----------|
|                  |  | I/P Days    | / O/P Visits | / Trips   | Full Time I   | Equi val ents  |          |
|                  | Component  | Title XVIII | Title XIX    | Total All | Total Interns | Employees On   |          |
|                  |  |             |              | Pati ents | & Residents   | Payrol I       |          |
|                  |  | 6. 00       | 7. 00        | 8. 00     | 9. 00         | 10.00          |          |
| 1.00             | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 | 955         | 0            | 1, 427    |               |                | 1.00     |
|                  | for the portion of LDP room available beds)  |             |              |           |               |                |          |
| 2.00             | HMO and other (see instructions)   | 215         | 120          |           |               |                | 2. 00    |
| 3.00             | HMO I PF Subprovi der  | o           | o            |           |               |                | 3. 00    |
| 4.00             | HMO IRF Subprovider  | o           | o            |           |               |                | 4. 00    |
| 5.00             | Hospital Adults & Peds. Swing Bed SNF  | 382         | o            | 382       |               |                | 5. 00    |
| 6.00             | Hospital Adults & Peds. Swing Bed NF   |             | o            | 281       |               |                | 6.00     |
| 7.00             | Total Adults and Peds. (exclude observation  | 1, 337      | o            | 2, 090    |               |                | 7. 00    |
|                  | beds) (see instructions)   |             |              | ·         |               |                |          |
| 8.00             | INTENSIVE CARE UNIT  | o           | o            | 0         |               |                | 8. 00    |
| 9.00             | CORONARY CARE UNIT   |             |              |           |               |                | 9. 00    |
| 10.00            | BURN INTENSIVE CARE UNIT   |             |              |           |               |                | 10.00    |
| 11.00            | SURGICAL INTENSIVE CARE UNIT   |             |              |           |               |                | 11. 00   |
| 12.00            | OTHER SPECIAL CARE (SPECIFY)   |             |              |           |               |                | 12.00    |
| 13.00            | NURSERY  |             | o            | 0         |               |                | 13. 00   |
| 14. 00           | Total (see instructions)   | 1, 337      | o            | 2. 090    | 0.00          | 139, 29        |          |
| 15. 00           | CAH vi si ts   | 0           | o            | 0         |               |                | 15. 00   |
| 16. 00           | SUBPROVI DER - I PF  |             | آ            |           |               |                | 16. 00   |
| 17. 00           | SUBPROVI DER - I RF  |             |              |           |               |                | 17. 00   |
| 18. 00           | SUBPROVI DER   |             |              |           |               |                | 18. 00   |
| 19. 00           | SKILLED NURSING FACILITY   |             |              |           |               |                | 19. 00   |
| 20. 00           | NURSING FACILITY   |             | İ            |           |               |                | 20.00    |
| 21. 00           | OTHER LONG TERM CARE   |             |              |           |               |                | 21.00    |
| 22. 00           | HOME HEALTH AGENCY   | 0           | 0            | 0         | 0.00          | 0.00           |          |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P. )  |             | ĭ            | O         | 0.00          | 0.00           | 23. 00   |
| 24. 00           | HOSPI CE   |             |              |           |               |                | 24. 00   |
| 24. 10           | HOSPICE (non-distinct part)  | 0           | 0            | 0         |               |                | 24. 10   |
| 25. 00           | CMHC - CMHC  | Ĭ           | ĭ            | O         |               |                | 25. 00   |
| 26. 00           | RURAL HEALTH CLINIC  |             |              |           |               |                | 26. 00   |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER  | 0           | 0            | 0         | 0.00          | 0.00           |          |
| 27. 00           | Total (sum of lines 14-26)   | ı           | ĭ            | O         | 0.00          |                |          |
| 28. 00           | Observation Bed Days   |             | 6            | 808       |               | 137.27         | 28. 00   |
| 29. 00           | Ambulance Trips  | 0           | ď            | 000       |               |                | 29. 00   |
| 30. 00           | Employee discount days (see instruction)   |             |              | 0         |               |                | 30.00    |
| 31. 00           | Employee discount days (see l'istruction)  |             |              | 0         |               |                | 31.00    |
|                  |  | 0           | 0            | 0         |               |                | 32.00    |
| 32. 00<br>32. 01 | Labor & delivery days (see instructions) Total ancillary labor & delivery room   |             | Y            | 0         |               |                | 32.00    |
| 32. UI           | outpatient days (see instructions)   |             |              | 0         |               |                | 32.01    |
| 33. 00           | LTCH non-covered days  | o           | -            |           |               |                | 33. 00   |
|                  | LTCH site neutral days and discharges  | 0           | -            |           |               |                | 33. 00   |
| 33.01            | TETOTI SI LE HEULT AL MAYS AND UI SCHALGES   | ı V         | I            |           |               | 1              | J 33. UT |

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: |

|        |   |               |          |             | 12/31/2017 | 5/25/2018 5: 2 |        |
|--------|---|---------------|----------|-------------|------------|----------------|--------|
|        |   | Full Time     | <u>'</u> | Di sch      | arges      |                |        |
|        |   | Equi val ents |          |             |            |                |        |
|        | Component   | Nonpai d      | Title V  | Title XVIII | Title XIX  | Total All      |        |
|        |   | Workers       |          |             |            | Pati ents      |        |
|        |   | 11. 00        | 12. 00   | 13. 00      | 14. 00     | 15. 00         |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) |               | 0        | 315         | 35         | 491            | 2.00   |
| 3.00   | HMO IPF Subprovider   |               |          | 70          | 0          |                | 3.00   |
| 4.00   | HMO IRF Subprovider   |               |          |             | 0          |                | 4.00   |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF   |               |          |             | U          |                | 5.00   |
| 6.00   | Hospital Adults & Peds. Swing Bed NF  |               |          |             |            |                | 6.00   |
| 7. 00  | Total Adults and Peds. (exclude observation   |               |          |             |            |                | 7.00   |
| 7.00   | beds) (see instructions)  |               |          |             |            |                | 7.00   |
| 8. 00  | INTENSIVE CARE UNIT   |               |          |             |            |                | 8. 00  |
| 9. 00  | CORONARY CARE UNIT  |               |          |             |            |                | 9. 00  |
| 10.00  | BURN INTENSIVE CARE UNIT  |               |          |             |            |                | 10.00  |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT  |               |          |             |            |                | 11. 00 |
| 12. 00 | OTHER SPECIAL CARE (SPECIFY)  |               |          |             |            |                | 12. 00 |
| 13. 00 | NURSERY   |               |          |             |            |                | 13. 00 |
| 14.00  | Total (see instructions)  | 0.00          | 0        | 315         | 0          | 491            | 14. 00 |
| 15.00  | CAH visits  |               |          |             |            |                | 15. 00 |
| 16.00  | SUBPROVI DER - I PF   |               |          |             |            |                | 16. 00 |
| 17.00  | SUBPROVI DER - I RF   |               |          |             |            |                | 17. 00 |
| 18.00  | SUBPROVI DER  |               |          |             |            |                | 18. 00 |
| 19.00  | SKILLED NURSING FACILITY  |               |          |             |            |                | 19. 00 |
| 20.00  | NURSING FACILITY  |               |          |             |            |                | 20. 00 |
| 21.00  | OTHER LONG TERM CARE  |               |          |             |            |                | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY  | 0. 00         |          |             |            |                | 22. 00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.)  |               |          |             |            |                | 23. 00 |
| 24. 00 | HOSPI CE  |               |          |             |            |                | 24. 00 |
| 24. 10 | HOSPICE (non-distinct part)   |               |          |             |            |                | 24. 10 |
| 25.00  | CMHC - CMHC   |               |          |             |            |                | 25. 00 |
| 26.00  | RURAL HEALTH CLINIC   |               |          |             |            |                | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER   | 0. 00         |          |             |            |                | 26. 25 |
| 27. 00 | Total (sum of lines 14-26)  | 0. 00         |          |             |            |                | 27. 00 |
| 28. 00 | Observation Bed Days  |               |          |             |            |                | 28. 00 |
| 29. 00 | Ambul ance Tri ps   |               |          |             |            |                | 29. 00 |
| 30. 00 | Employee discount days (see instruction)  |               |          |             |            |                | 30. 00 |
| 31. 00 | Employee discount days - IRF  |               |          |             |            |                | 31.00  |
| 32. 00 | Labor & delivery days (see instructions)  |               |          |             |            |                | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room   |               |          |             |            |                | 32. 01 |
| 00.05  | outpatient days (see instructions)  |               |          | _           |            |                | 00.00  |
| 33. 00 | LTCH non-covered days   |               |          | 0           |            |                | 33.00  |
| 33. 01 | LTCH site neutral days and discharges   | 1             |          | 0           |            |                | 33. 01 |

| Health Financial Systems IU HEALTH WH  | ITE HOSPITAL   |                  | In Lie                           | u of Form CMS-2                  | 2552-10                    |  |  |  |  |  |
|--|--|------------------|----------------------------------|----------------------------------|----------------------------|--|--|--|--|--|
| HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA  | Provi der CC   |                  | Peri od:                         | Worksheet S-10                   |                            |  |  |  |  |  |
|  |  |                  | From 01/01/2017<br>To 12/31/2017 | Date/Time Prep<br>5/25/2018 5:20 |                            |  |  |  |  |  |
|  |  | 1                |                                  |                                  |                            |  |  |  |  |  |
|  |  |                  |                                  | 1. 00                            |                            |  |  |  |  |  |
| Uncompensated and indigent care cost computation  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column   | 2 divided by Lie   | no 202 column    | 0)                               | 0. 319148                        | 1. 00                      |  |  |  |  |  |
| Medicaid (see instructions for each line)  | 3 divided by iii   | ne 202 coi ullin | 8)                               | 0.319148                         | 1.00                       |  |  |  |  |  |
| 2.00 Net revenue from Medicaid   |  |                  |                                  |                                  |                            |  |  |  |  |  |
| 3.00 Did you receive DSH or supplemental payments from Medicaid  | Did you receive DSH or supplemental payments from Medicaid?  |                  |                                  |                                  |                            |  |  |  |  |  |
| 4.00 If line 3 is yes, does line 2 include all DSH and/or suppl  |  |                  | i d?                             | Y                                | 4. 00                      |  |  |  |  |  |
| 5.00 If line 4 is no, then enter DSH and/or supplemental paymen  | its from Medicai   | d                |                                  | 0                                | 5.00                       |  |  |  |  |  |
| 6.00   Medicaid charges<br>7.00   Medicaid cost (line 1 times line 6)  |  |                  |                                  | 11, 263, 145<br>3, 594, 610      | 6. 00<br>7. 00             |  |  |  |  |  |
| 8.00 Difference between net revenue and costs for Medicaid prog  | ıram (line 7 min   | us sum of lin    | es 2 and 5 if                    | 1, 013, 662                      |                            |  |  |  |  |  |
| < zero then enter zero)  | ,  | ao oa o          | 00 L and 0, 1.                   | ., 0.0, 002                      | 0.00                       |  |  |  |  |  |
| Children's Health Insurance Program (CHIP) (see instruction  | ns for each line   | e)               |                                  |                                  |                            |  |  |  |  |  |
| 9.00 Net revenue from stand-al one CHIP  |  |                  |                                  | 0                                |                            |  |  |  |  |  |
| 10.00   Stand-alone CHIP charges 11.00   Stand-alone CHIP cost (line 1 times line 10)  |  |                  |                                  | 0                                |                            |  |  |  |  |  |
| 11.00   Stand-alone CHIP cost (line 1 times line 10) 12.00   Difference between net revenue and costs for stand-alone C  | HIP (line 11 mi)   | nus line 9·i     | f < zero then                    | 0                                |                            |  |  |  |  |  |
| enter zero)  | ann (nne ni iiin   | nus Tine 7, T    | 1 \ Zero then                    | ٥                                | 12.00                      |  |  |  |  |  |
| Other state or local government indigent care program (see   |  |                  |                                  |                                  |                            |  |  |  |  |  |
| 13.00 Net revenue from state or local indigent care program (Not   |  |                  |                                  | -                                | 13. 00                     |  |  |  |  |  |
| 14.00 Charges for patients covered under state or local indigent   | care program (   | Not included     | in lines 6 or                    | 0                                | 14. 00                     |  |  |  |  |  |
| 10) 15.00 State or local indigent care program cost (line 1 times li   | ne 14)   |                  |                                  | o                                | 15. 00                     |  |  |  |  |  |
| 16.00 Difference between net revenue and costs for state or local  |  | program (lin     | e 15 minus line                  | o o                              |                            |  |  |  |  |  |
| 13; if < zero then enter zero)   |  |                  |                                  |                                  |                            |  |  |  |  |  |
| Grants, donations and total unreimbursed cost for Medicaid instructions for each line)   | , CHIP and state   | e/Local indig    | ent care program                 | ns (see                          |                            |  |  |  |  |  |
| 17.00 Private grants, donations, or endowment income restricted  |  |                  |                                  |                                  | 17. 00                     |  |  |  |  |  |
| 18.00 Government grants, appropriations or transfers for support   |  |                  | ( 61:                            | 0                                | 18.00                      |  |  |  |  |  |
| 19.00 Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16)   | rocai indigent o   | care programs    | (sum or lines                    | 1, 013, 662                      | 19.00                      |  |  |  |  |  |
| of 12 and 10)  |  | Uni nsured       | Insured                          | Total (col. 1                    |                            |  |  |  |  |  |
|  |  | pati ents        | pati ents                        | + col . 2)                       |                            |  |  |  |  |  |
| Unananantal Cara (and instructions for each line)  |  | 1. 00            | 2. 00                            | 3. 00                            |                            |  |  |  |  |  |
| Uncompensated Care (see instructions for each line)  20.00 Charity care charges and uninsured discounts for the entir  | re facility  | 1, 967, 94       | 1 121, 844                       | 2, 089, 785                      | 20.00                      |  |  |  |  |  |
| (see instructions)   | o ruoi i rig   | 1, 707, 71       | 121,011                          | 2,007,700                        | 20.00                      |  |  |  |  |  |
| 21.00 Cost of patients approved for charity care and uninsured d   | liscounts (see   | 628, 06          | 4 121, 844                       | 749, 908                         | 21. 00                     |  |  |  |  |  |
| instructions)  | 66   | 0.4 0=           |                                  | a. a=a                           |                            |  |  |  |  |  |
| 22.00 Payments received from patients for amounts previously wri   | tten off as  | 36, 37           | 2 0                              | 36, 372                          | 22.00                      |  |  |  |  |  |
| 23.00 Cost of charity care (line 21 minus line 22)   |  | 591, 69          | 2 121, 844                       | 713, 536                         | 23. 00                     |  |  |  |  |  |
|  | ·  | ,                |                                  |                                  |                            |  |  |  |  |  |
|  |  |                  |                                  | 1.00                             |                            |  |  |  |  |  |
| 24.00 Does the amount on line 20 column 2, include charges for p   |  | ond a Length     | of stay limit                    | N                                | 24. 00                     |  |  |  |  |  |
| 25.00 If line 24 is yes, enter the charges for patient days beyo   | imposed on patients covered by Medicaid or other indigent care program?  10 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of |                  |                                  |                                  |                            |  |  |  |  |  |
| stay limit   |  | 2, 453, 054      | 26. 00                           |                                  |                            |  |  |  |  |  |
| 26 UU LIOTAL DAG GEDT EXDENSE TOE THE ENTIRE HOSDITAL COMMINA ISE  | ructions)  |                  | 441, 312                         |                                  |                            |  |  |  |  |  |
| 26.00 Total bad debt expense for the entire hospital complex (se 27.00 Medicare reimbursable bad debts for the entire hospital co  |  |                  |                                  |                                  |                            |  |  |  |  |  |
| 27.00 Medicare reimbursable bad debts for the entire hospital co   |  |                  |                                  |                                  |                            |  |  |  |  |  |
| 27.00 Medicare reimbursable bad debts for the entire hospital co<br>27.01 Medicare allowable bad debts for the entire hospital compl<br>28.00 Non-Medicare bad debt expense (see instructions)   | ex (see instruc  | tions)           |                                  | 1, 774, 112                      | 28. 00                     |  |  |  |  |  |
| 27.00 Medicare reimbursable bad debts for the entire hospital compl<br>27.01 Medicare allowable bad debts for the entire hospital compl<br>28.00 Non-Medicare bad debt expense (see instructions)<br>29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt | ex (see instruction of expense (see i  | tions)           |                                  | 1, 774, 112<br>803, 834          | 28. 00<br>29. 00           |  |  |  |  |  |
| 27.00 Medicare reimbursable bad debts for the entire hospital co<br>27.01 Medicare allowable bad debts for the entire hospital compl<br>28.00 Non-Medicare bad debt expense (see instructions)   | ex (see instruction texpense (see instruction)   | tions)           |                                  | 1, 774, 112                      | 28. 00<br>29. 00<br>30. 00 |  |  |  |  |  |

| Heal th          | Financial Systems   | IU HEALTH WHITE     | HOSPI TAL           |                      | In Lie                           | u of Form CMS-2         | 2552-10          |
|------------------|---|---------------------|---------------------|----------------------|----------------------------------|-------------------------|------------------|
| RECLAS           | SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O                           | F EXPENSES          | Provi der Co        |                      | Peri od:                         | Worksheet A             |                  |
|                  |   |                     |                     |                      | From 01/01/2017<br>To 12/31/2017 | Date/Time Pre           | narod:           |
|                  |   |                     |                     |                      | 10 12/31/2017                    | 5/25/2018 5: 2          |                  |
|                  | Cost Center Description   | Sal ari es          | 0ther               | Total (col. 1        | Recl assi fi cati                | Recl assi fi ed         |                  |
|                  |   |                     |                     | + col. 2)            | ons (See A-6)                    | Trial Balance           |                  |
|                  |   |                     |                     |                      |                                  | (col. 3 +-              |                  |
|                  |   | 1.00                | 2.00                | 2.00                 | 4.00                             | col . 4)                |                  |
|                  | GENERAL SERVICE COST CENTERS  | 1. 00               | 2.00                | 3. 00                | 4. 00                            | 5. 00                   |                  |
| 1. 00            | 00100 CAP REL COSTS-BLDG & FLXT   |                     | 2, 027, 109         | 2, 027, 109          | 9 -2, 015, 531                   | 11, 578                 | 1.00             |
| 1. 01            | 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL                              |                     | 0,027,107           | 2,027,10             | 2, 795, 293                      | 2, 795, 293             | 1. 01            |
| 1. 02            | 00102 CAP REL COSTS-BLDG & FIXT - TLMOB                                 |                     | 0                   |                      | 283, 112                         | 283, 112                | 1. 02            |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT                                      | o                   | 46, 419             | 46, 419              |                                  | 1, 502, 585             | 4. 00            |
| 5.00             | 00500 ADMINISTRATIVE & GENERAL  | 638, 951            | 5, 208, 502         | 5, 847, 453          | 3 -20, 629                       | 5, 826, 824             | 5. 00            |
| 7.00             | 00700 OPERATION OF PLANT  | 202, 581            | 1, 575, 393         | 1, 777, 97           |                                  | 193, 520                | 7. 00            |
| 7. 01            | 00701 OPERATION OF PLANT - HOSPITAL                                     | 0                   | 0                   | (                    | 1, 498, 126                      |                         | 7. 01            |
| 7. 02            | 00702 OPERATION OF PLANT - TLMOB  | 0                   | 0                   | (                    | 264, 338                         |                         | 7. 02            |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE   | 0                   | 0                   | (                    | 0 65, 338                        | 65, 338                 | 8. 00            |
| 9.00             | 00900 HOUSEKEEPI NG   | 303, 179            | 247, 624            |                      |                                  | 362, 086                | 9.00             |
| 10. 00<br>11. 00 | 01000 DI ETARY<br>01100 CAFETERI A                                      | 507, 134            | 384, 842            |                      | - 305, 895<br>100, 274           | 586, 081<br>100, 274    | 10. 00<br>11. 00 |
| 13. 00           | 01300 NURSING ADMINISTRATION  | 764, 567            | 238, 652            |                      |                                  | 873, 329                | 13.00            |
| 14. 00           | 01400 CENTRAL SERVI CES & SUPPLY  | 704, 307            | 7, 771              |                      |                                  | 517, 176                | 14. 00           |
| 15. 00           | 01500 PHARMACY  | 381, 643            | 1, 765, 054         |                      |                                  | 429, 743                | 15. 00           |
| 16. 00           | 01600 MEDICAL RECORDS & LIBRARY   | 0                   | 0                   |                      | 0                                | 0                       | 16. 00           |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS                                  |                     |                     |                      | <u>'</u>                         |                         |                  |
| 30.00            | 03000 ADULTS & PEDIATRICS   | 1, 242, 854         | 628, 320            | 1, 871, 17           | 4 -349, 690                      | 1, 521, 484             | 30. 00           |
| 31.00            | 03100 INTENSIVE CARE UNIT   | 0                   | 0                   | (                    | 0                                | 0                       | 31. 00           |
| 43.00            | 04300 NURSERY   | 0                   | 0                   | (                    | 0 0                              | 0                       | 43. 00           |
|                  | ANCILLARY SERVICE COST CENTERS  |                     |                     |                      |                                  |                         |                  |
| 50.00            | 05000 OPERATING ROOM  | 486, 802            | 714, 995            | 1, 201, 79           | 7 -378, 244                      | 823, 553                | 50.00            |
| 52.00            | 05200 DELIVERY ROOM & LABOR ROOM  | 200 744             | 227 041             | (25.00)              | J 0                              | 0<br>369, 633           | 52. 00<br>54. 00 |
| 54. 00<br>55. 00 | 05400 RADI OLOGY-DI AGNOSTI C<br>05500 RADI OLOGY-THERAPEUTI C          | 298, 744<br>70, 344 | 337, 061<br>78, 254 | 635, 809<br>148, 598 |                                  | 98, 996                 | 55.00            |
| 56. 00           | 03630 ULTRA SOUND   | 53, 226             | 165, 732            |                      |                                  | 140, 176                | •                |
| 57. 00           | 05700 CT SCAN   | 285, 954            | 227, 587            |                      |                                  | 309, 196                | 57. 00           |
| 58. 00           | 05800 MAGNETIC RESONANCE IMAGING (MRI)                                  | 110, 213            | 186, 341            |                      |                                  | 120, 279                | 58. 00           |
| 60.00            | 06000 LABORATORY  | O                   | 1, 219, 471         |                      |                                  | 1, 220, 379             | 60.00            |
| 66.00            | 06600 PHYSI CAL THERAPY   | 271, 209            | 91, 557             | 362, 766             | 6 -72, 804                       | 289, 962                | 66. 00           |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY   | 107, 912            | 24, 097             |                      |                                  | 115, 988                | 67. 00           |
| 68. 00           | 06800 SPEECH PATHOLOGY  | 69, 916             | 22, 189             |                      |                                  | 78, 198                 | 1                |
| 69. 00           | 06900 ELECTROCARDI OLOGY  | 144, 617            | 37, 280             |                      |                                  | 156, 611                | 69. 00           |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                              | 0                   | 0                   | 9                    | 21, 124                          | 21, 124                 | 1                |
| 72. 00<br>73. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS<br>07300 DRUGS CHARGED TO PATIENTS | 0                   | 0                   |                      | 5, 686<br>429, 459               |                         | 72. 00<br>73. 00 |
|                  | 07300 DRUGS CHARGED TO PATTENTS   | 0                   | 0                   | )                    | 1, 248, 597                      | 429, 459<br>1, 248, 597 | 73.00            |
|                  | 03020 CARDI OPULMONARY  | 340, 837            | 137, 157            | 477, 99              |                                  | 367, 391                | 76.00            |
| 70.00            | OUTPATIENT SERVICE COST CENTERS   | 340,037             | 137, 137            | 7/1, //-             | 110,003                          | 307, 371                | 70.00            |
| 90.00            | 09000 CLI NI C  | 114, 786            | 74, 885             | 189, 67              | 1 -34, 225                       | 155, 446                | 90.00            |
| 91.00            | 09100 EMERGENCY   | 1, 112, 920         | 1, 323, 361         |                      |                                  | 2, 061, 607             | 91.00            |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                              |                     |                     |                      |                                  |                         | 92.00            |
| 92. 01           | 09201 OBSERVATION BEDS (DISTINCT PART)                                  | 0                   | 0                   | (                    | 0 0                              | 0                       | 92. 01           |
|                  | OTHER REIMBURSABLE COST CENTERS   |                     |                     |                      |                                  |                         |                  |
| 101. 00          | 10100 HOME HEALTH AGENCY  | 0                   | 0                   | (                    | 0 0                              | 0                       | 101. 00          |
| 440.00           | SPECIAL PURPOSE COST CENTERS  | 7 500 000           | 4/ 7/0 /50          | 04.070.044           | 5/5 40/                          | 04.040.440              | 440.00           |
| 118. 00          |   | 7, 508, 389         | 16, 769, 653        | 24, 278, 042         | 2 565, 126                       | 24, 843, 168            | 1118.00          |
| 100.00           | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | ٥                   |                     | 1 ,                  | 0                                | 0                       | 190. 00          |
|                  | 19100 RESEARCH  | 0                   | 0                   | )                    | 0                                |                         | 190.00           |
|                  | 19200 PHYSICIANS' PRIVATE OFFICES                                       | 84, 148             | 24, 031             | 108, 179             | 9 -17, 676                       |                         | 191.00           |
|                  | 19202 MOB   | 07, 170             | 547, 450            |                      |                                  |                         | 192. 00          |
|                  | 19203 ARNETT SURGERY OFFICE   | ő                   | 0                   | 3.7, 100             | 0                                |                         | 192. 03          |
|                  | 19201 OCCUPATI ONAL MEDI CI NE  | o                   | 0                   | į (                  | o o                              |                         | 192. 04          |
|                  | 19300 NONPALD WORKERS   | o                   | 0                   | (                    | 0                                |                         | 193. 00          |
| 200.00           | TOTAL (SUM OF LINES 118 through 199)                                    | 7, 592, 537         | 17, 341, 134        | 24, 933, 67          | 1 0                              | 24, 933, 671            | 200. 00          |
|                  |   |                     |                     |                      |                                  |                         |                  |

Peri od: From 01/01/2017 To 12/31/2017

Date/Time Prepared: 5/25/2018 5:20 pm

|        |  |              |                | 5/25/2018 5: 2   | U pili  |
|--------|--|--------------|----------------|--|---------|
|        | Cost Center Description                    | Adjustments  | Net Expenses   |  |         |
|        |  | (See A-8)    | For Allocation |  |         |
|        |  | 6. 00        | 7. 00          |  |         |
|        | GENERAL SERVICE COST CENTERS               |              |                |  |         |
| 1.00   | 00100 CAP REL COSTS-BLDG & FIXT            | 85, 595      | 97, 173        |  | 1.00    |
| 1. 01  | 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL | 208, 614     | 1              |  | 1. 01   |
| 1. 02  | 00102 CAP REL COSTS-BLDG & FIXT - TLMOB    | 359, 643     | 1              |  | 1. 02   |
|        |  |              | 1              |  | 1       |
| 4.00   | 00400 EMPLOYEE BENEFITS DEPARTMENT         | -263, 038    | 1              |  | 4. 00   |
| 5.00   | 00500 ADMINISTRATIVE & GENERAL             | -1, 146, 093 | 1              |  | 5. 00   |
| 7.00   | 00700 OPERATION OF PLANT                   | 37, 041      | 230, 561       |  | 7. 00   |
| 7.01   | 00701 OPERATION OF PLANT - HOSPITAL        | 80, 927      | 1, 579, 053    |  | 7. 01   |
| 7.02   | 00702 OPERATION OF PLANT - TLMOB           | 0            | 264, 338       |  | 7. 02   |
| 8.00   | 00800 LAUNDRY & LINEN SERVICE              | 0            | 65, 338        |  | 8. 00   |
| 9.00   | 00900 HOUSEKEEPI NG                        | 18, 881      | 380, 967       |  | 9. 00   |
| 10.00  | 01000 DI ETARY                             | -193, 843    | 1              |  | 10.00   |
| 11. 00 | 01100 CAFETERI A                           | -84, 294     |                | l .  | 11. 00  |
| 13. 00 | 01300 NURSI NG ADMI NI STRATI ON           | -36, 021     | 837, 308       |  | 13. 00  |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY            |              | 1              |  | 14. 00  |
|        |  | -11, 038     | 1              |  |         |
| 15.00  | 01500 PHARMACY                             | 148, 081     | 577, 824       |  | 15.00   |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY            | 0            | 0              |  | 16. 00  |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     | 1            | r              |  | 1       |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS                | -133, 746    | 1, 387, 738    |  | 30. 00  |
| 31. 00 | 03100 INTENSIVE CARE UNIT                  | 0            | 0              |  | 31.00   |
| 43.00  | 04300 NURSERY                              | 0            | 0              |  | 43.00   |
|        | ANCILLARY SERVICE COST CENTERS             |              |                |  |         |
| 50.00  | 05000 OPERATING ROOM                       | -122, 222    | 701, 331       |  | 50. 00  |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM           | 0            | 0              |  | 52.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | -3, 687      | 365, 946       |  | 54.00   |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C              | -47          | 98, 949        | l control of the cont | 55. 00  |
| 56. 00 | 03630 ULTRA SOUND                          | 0            | 1              |  | 56.00   |
| 57. 00 | 05700 CT SCAN                              |              |                |  | 57.00   |
|        |  | 0            | 309, 196       |  | 1       |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI)    | 0            |                |  | 58. 00  |
| 60. 00 | 06000 LABORATORY                           | 0            |                |  | 60.00   |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 0            | 289, 962       |  | 66. 00  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 0            | 115, 988       |  | 67.00   |
| 68.00  | 06800 SPEECH PATHOLOGY                     | 0            | 78, 198        |  | 68. 00  |
| 69.00  | 06900 ELECTROCARDI OLOGY                   | 16, 178      | 172, 789       |  | 69. 00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0            | 21, 124        |  | 71.00   |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 0            | 1              |  | 72.00   |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS            | 0            | l              |  | 73. 00  |
| 73. 01 | 07301 ONCOLOGY DRUGS                       | 0            |                |  | 73. 01  |
|        |  |              |                |  | 1       |
| 76. 00 | 03020 CARDI OPULMONARY                     | 0            | 367, 391       |  | 76. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |              | 155 444        |  |         |
| 90.00  | 09000 CLI NI C                             | 0            |                | ·  | 90.00   |
| 91. 00 | 09100 EMERGENCY                            | 87, 061      | 2, 148, 668    |  | 91.00   |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) |              |                |  | 92. 00  |
| 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0            | 0              |  | 92. 01  |
|        | OTHER REIMBURSABLE COST CENTERS            |              |                |  |         |
| 101.00 | 10100 HOME HEALTH AGENCY                   | 0            | 0              |  | 101. 00 |
|        | SPECIAL PURPOSE COST CENTERS               |              |                |  |         |
| 118.00 |  | -952, 008    | 23, 891, 160   |  | 118. 00 |
|        | NONREI MBURSABLE COST CENTERS              | 702,000      | 20,0,1,100     |  | 1       |
| 190 00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0            | 0              |  | 190. 00 |
|        | 1  | 0            |                |  |         |
|        | 19100 RESEARCH                             |              | 00 500         |  | 191.00  |
|        | 19200 PHYSI CLANS' PRI VATE OFFI CES       | 0            | 90, 503        |  | 192. 00 |
|        | 2 19202 MOB                                | 0            | 0              |  | 192. 02 |
|        | 19203 ARNETT SURGERY OFFICE                | 0            | 0              |  | 192. 03 |
|        | 19201 OCCUPATIONAL MEDICINE                | 0            | 0              |  | 192. 04 |
|        | 19300 NONPALD WORKERS                      | 0            | 0              |  | 193. 00 |
| 200.00 | TOTAL (SUM OF LINES 118 through 199)       | -952, 008    | 23, 981, 663   |  | 200. 00 |
|        |  |              |                |  |         |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1312

|                  |  |                  |                             |                            | To 12/31/2017 | 7 Date/Time Prepared:<br>5/25/2018 5:20 pm |
|------------------|--|------------------|-----------------------------|----------------------------|---------------|--|
|                  | Cost Center                                  | Increases Line # | Salary                      | Other                      |               |  |
|                  | 2. 00  | 3. 00            | 4. 00                       | 5. 00                      |               |  |
|                  | A - CAFETERIA                                |                  |                             |                            |               |  |
| 1. 00            | CAFETERI A                                   | 11.00            | 7 <u>2, 5</u> 68<br>72, 568 | <u>27, 7</u> 06<br>27, 706 |               | 1.00                                       |
|                  | B - DRUGS EXPENSE                            |                  | 72, 500                     | 27,700                     |               |  |
| 1.00             | DRUGS CHARGED TO PATIENTS                    | 73. 00           | 0                           | 429, 459                   |               | 1. 00                                      |
| 2.00             | ONCOLOGY DRUGS                               | 73. 01           | 0                           | 1, 248, 597                |               | 2.00                                       |
| 3. 00<br>4. 00   |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 3. 00<br>4. 00                             |
| 5. 00            |  | 0.00             | o                           | Ö                          |               | 5. 00                                      |
| 6.00             |  | 0.00             | 0                           | 0                          |               | 6. 00                                      |
| 7. 00<br>8. 00   |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 7. 00<br>8. 00                             |
| 9. 00            |  | 0.00             | o                           | 0                          |               | 9. 00                                      |
| 10.00            |  | 0. 00            | O                           | 0                          |               | 10.00                                      |
| 11.00            |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 11.00                                      |
| 12. 00<br>13. 00 |  | 0.00             | 0                           | 0                          |               | 12. 00<br>13. 00                           |
| 14. 00           |  | 0.00             | 0                           | 0                          |               | 14. 00                                     |
|                  | O C - MEDICAL SUPPLIES AND REBA              | TEC              | 0                           | 1, 678, 056                |               |  |
| 1.00             | CENTRAL SERVICES & SUPPLY                    | 14. 00           | 0                           | 514, 942                   |               | 1. 00                                      |
| 2. 00            | MEDICAL SUPPLIES CHARGED TO                  | 71. 00           | Ö                           | 21, 124                    |               | 2. 00                                      |
| 2 00             | PATIENTS IMPL. DEV. CHARGED TO               | 72.00            | 0                           | E 404                      |               | 2.00                                       |
| 3. 00            | PATIENTS                                     | 72.00            | U                           | 5, 686                     |               | 3.00                                       |
| 4.00             | EMPLOYEE BENEFITS DEPARTMENT                 | 4.00             | О                           | 10                         |               | 4. 00                                      |
| 5. 00<br>6. 00   | LABORATORY                                   | 60. 00<br>0. 00  | 0                           | 908                        |               | 5. 00                                      |
| 7.00             |  | 0.00             | 0                           | 0                          |               | 6. 00<br>7. 00                             |
| 8.00             |  | 0.00             | O                           | 0                          |               | 8. 00                                      |
| 9.00             |  | 0.00             | 0                           | 0                          |               | 9.00                                       |
| 10. 00<br>11. 00 |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 10. 00<br>11. 00                           |
| 12. 00           |  | 0.00             | o                           | 0                          |               | 12. 00                                     |
| 13.00            |  | 0.00             | 0                           | 0                          |               | 13.00                                      |
| 14. 00<br>15. 00 |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 14. 00<br>15. 00                           |
| 16. 00           |  | 0.00             | o                           | Ö                          |               | 16. 00                                     |
| 17. 00           |  | 0.00             | 0                           | 0                          |               | 17. 00                                     |
| 18. 00<br>19. 00 |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 18. 00<br>19. 00                           |
| 20. 00           |  | 0.00             | Ö                           | 0                          |               | 20. 00                                     |
|                  | 0  |                  | 0                           | 542, 670                   |               |  |
| 1. 00            | D - LAUNDRY LAUNDRY & LINEN SERVICE          | 8. 00            | 0                           | 65, 338                    |               | 1.00                                       |
| 2.00             |  | 0.00             | 0                           | 0                          |               | 2. 00                                      |
|                  | O DEPOS ATLON                                |                  | 0                           | 65, 338                    |               |  |
| 1. 00            | E - DEPRECIATION CAP REL COSTS-BLDG & FIXT - | 1. 01            | O                           | 1, 683, 362                |               | 1. 00                                      |
| 1.00             | HOSPI TAL                                    |                  | Ĭ                           |                            |               | 1.00                                       |
| 2.00             | CAP REL COSTS-BLDG & FIXT -                  | 1. 02            | 0                           | 253, 366                   |               | 2. 00                                      |
| 3.00             | TLMOB  | 0. 00            | o                           | 0                          |               | 3. 00                                      |
| 4.00             |  | 0. 00            | О                           | 0                          |               | 4. 00                                      |
| 5.00             |  | 0.00             | 0                           | 0                          |               | 5. 00                                      |
| 6. 00<br>7. 00   |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 6. 00<br>7. 00                             |
| 8. 00            |  | 0. 00            | O                           | 0                          |               | 8. 00                                      |
| 9.00             |  | 0.00             | 0                           | 0                          |               | 9.00                                       |
| 10. 00<br>11. 00 |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 10. 00<br>11. 00                           |
| 12. 00           |  | 0.00             | Ö                           | 0                          |               | 12. 00                                     |
| 13.00            |  | 0.00             | 0                           | 0                          |               | 13. 00                                     |
| 14. 00<br>15. 00 |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 14. 00<br>15. 00                           |
| 16.00            |  | 0. 00            | 0                           | Ö                          |               | 16. 00                                     |
| 17. 00           |  | 0.00             | 0                           | 0                          |               | 17. 00                                     |
| 18. 00<br>19. 00 |  | 0. 00<br>0. 00   | 0                           | 0                          |               | 18. 00<br>19. 00                           |
| 20. 00           |  | 0.00             | 0                           | 0                          |               | 20. 00                                     |
| 21.00            |  | 0.00             | O                           | 0                          |               | 21. 00                                     |
| 22. 00           |  |                  | <del>0</del>                | 0<br>0<br>1, 936, 728      |               | 22. 00                                     |
|                  | l <sub>0</sub>                               | ı                | 이                           | 1, 730, 720                |               |  |

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1312 

|                  |                                      |                |                    |                     | 5/25/2018 5: 20 p                     |                |
|------------------|--------------------------------------|----------------|--------------------|---------------------|---------------------------------------|----------------|
|                  |                                      | Increases      |                    |                     |                                       |                |
|                  | Cost Center                          | Li ne #        | Sal ary            | 0ther               |                                       |                |
|                  | 2. 00                                | 3. 00          | 4. 00              | 5. 00               |                                       |                |
|                  | F - OTHER CAPITAL EXPENSES           |                |                    |                     |                                       |                |
| 1. 00            | CAP REL COSTS-BLDG & FIXT - HOSPITAL | 1. 01          | 0                  | 1, 088, 244         |                                       | 1. 00          |
| 2. 00            | CAP REL COSTS-BLDG & FIXT - HOSPITAL | 1. 01          | 0                  | 24, 337             | -                                     | 2. 00          |
| 3.00             | PHARMACY                             | 15. 00         | o                  | 650                 | ;                                     | 3. 00          |
| 4. 00            | CAP REL COSTS-BLDG & FIXT -          | 1. 02          | O                  | 29, 746             |                                       | 4. 00          |
|                  | TOTALS                               | +              | +                  | <u>1, 142, 9</u> 77 |                                       |                |
|                  | G - OPERATION OF PLANT               |                |                    | 17 1127 777         |                                       |                |
| 1.00             | OPERATION OF PLANT -                 | 7. 01          | 0                  | 1, 498, 126         |                                       | 1. 00          |
|                  | HOSPI TAL                            |                |                    | ,                   |                                       |                |
| 2.00             | OPERATION OF PLANT - TLMOB           | 7. 02          | o                  | 264, 338            |                                       | 2. 00          |
|                  | 0                                    |                | 0                  | 1, 762, 464         |                                       |                |
|                  | H - EMPLOYEE BENEFITS                |                |                    |                     |                                       |                |
| 1.00             | EMPLOYEE BENEFITS DEPARTMENT         | 4.00           | 0                  | 1, 461, 334         |                                       | 1. 00          |
| 2.00             |                                      | 0.00           | 0                  | 0                   |                                       | 2.00           |
| 3.00             |                                      | 0.00           | 0                  | 0                   |                                       | 3.00           |
| 4.00             |                                      | 0.00           | 0                  | 0                   |                                       | 4. 00          |
| 5.00             |                                      | 0.00           | 0                  | 0                   |                                       | 5.00           |
| 6.00             |                                      | 0.00           | 0                  | 0                   |                                       | 6. 00          |
| 7.00             |                                      | 0.00           | 0                  | 0                   |                                       | 7.00           |
| 8.00             |                                      | 0.00           | 0                  | 0                   |                                       | 8.00           |
| 9.00             |                                      | 0.00           | 0                  | 0                   |                                       | 9.00           |
| 10.00            |                                      | 0.00           | 0                  |                     |                                       | 0.00           |
| 11. 00<br>12. 00 |                                      | 0. 00<br>0. 00 | 0                  | 0                   |                                       | 1.00           |
| 13. 00           |                                      |                | 0                  | 0                   |                                       | 2.00           |
| 14. 00           |                                      | 0. 00<br>0. 00 | 0                  | 0                   |                                       | 3. 00<br>4. 00 |
| 15. 00           |                                      | 0.00           | 0                  | 0                   |                                       | 5. 00          |
| 16. 00           |                                      | 0.00           | 0                  | 0                   |                                       | 6. 00          |
| 17. 00           |                                      | 0.00           | 0                  | 0                   |                                       | 7. 00          |
| 18. 00           |                                      | 0.00           | 0                  | 0                   | 1                                     | 8. 00          |
| 19. 00           |                                      | 0.00           | 0                  | 0                   | 1                                     | 9. 00          |
| 20. 00           |                                      | 0.00           | 0                  | 0                   | · · · · · · · · · · · · · · · · · · · | 0.00           |
| 21. 00           |                                      | 0.00           | o                  | 0                   |                                       | 1. 00          |
| 21.00            |                                      |                | — — — <del>ў</del> | 1, 461, 334         |                                       | 1.00           |
|                  | I - HOUSEKEEPING SUPPLIES            |                | <u> </u>           | 1, 101, 001         |                                       |                |
| 1.00             | HOUSEKEEPI NG                        | 9.00           | 0                  | 7, 490              |                                       | 1. 00          |
| 2.00             |                                      | 0.00           | O                  | 0                   |                                       | 2. 00          |
| 3.00             |                                      | 0.00           | 0                  | 0                   |                                       | 3. 00          |
| 4.00             |                                      | 0.00           | 0                  | 0                   | 4                                     | 4. 00          |
| 5.00             |                                      | 0.00           | 0                  | 0                   | !                                     | 5. 00          |
| 6.00             |                                      | 0.00           | 0                  | 0                   |                                       | 6. 00          |
| 7.00             |                                      | 0.00           | 0                  | 0                   |                                       | 7. 00          |
| 8.00             |                                      | 0.00           | 0                  | 0                   |                                       | 8. 00          |
| 9.00             |                                      | 0.00           | 0                  | 0                   |                                       | 9. 00          |
| 10.00            |                                      | 0.00           |                    | 0                   | 10                                    | 0. 00          |
|                  | 0                                    |                | 0                  | 7, 490              |                                       |                |
|                  | J - NON-CAPITAL EXPENSES             |                |                    |                     |                                       |                |
| 1.00             | ADMI NI STRATI VE & GENERAL          |                | •                  | 12 <u>1, 3</u> 67   |                                       | 1. 00          |
|                  | TOTALS                               |                | 0                  | 121, 367            |                                       | _              |
| 500.00           | Grand Total: Increases               |                | 72, 568            | 8, 746, 130         | 500                                   | 0. 00          |

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/25/2018 5: 20 pm

|        |                               |           |                  |                  |                | 5/25/2018 5: 2 | 20 pm  |
|--------|-------------------------------|-----------|------------------|------------------|----------------|----------------|--------|
|        |                               | Decreases |                  |                  | _              |                |        |
|        | Cost Center                   | Li ne #   | Sal ary          | Other            | Wkst. A-7 Ref. |                |        |
|        | 6. 00                         | 7. 00     | 8. 00            | 9. 00            | 10. 00         |                |        |
|        | A - CAFETERIA                 |           |                  |                  |                |                |        |
| 1.00   | DI ETARY                      | 1000      | 7 <u>2, 5</u> 68 | 2 <u>7, 7</u> 06 |                |                | 1. 00  |
|        | 0                             |           | 72, 568          | 27, 706          |                |                |        |
|        | B - DRUGS EXPENSE             |           |                  |                  |                |                |        |
| 1.00   | EMPLOYEE BENEFITS DEPARTMENT  | 4. 00     |                  | 3, 764           |                |                | 1. 00  |
| 2.00   | CENTRAL SERVICES & SUPPLY     | 14. 00    |                  | 192              |                |                | 2. 00  |
| 3.00   | PHARMACY                      | 15. 00    |                  | 1, 623, 227      |                |                | 3. 00  |
| 4.00   | ADULTS & PEDIATRICS           | 30.00     |                  | 7, 290           | 1              |                | 4. 00  |
| 5.00   | OPERATING ROOM                | 50.00     |                  | 2, 601           |                |                | 5. 00  |
| 6.00   | RADI OLOGY-DI AGNOSTI C       | 54.00     |                  | 2, 898           | 0              |                | 6. 00  |
| 7.00   | RADI OLOGY-THERAPEUTI C       | 55.00     |                  | 18, 187          | 0              |                | 7. 00  |
| 8.00   | CT SCAN                       | 57.00     |                  | 3, 020           | 0              |                | 8. 00  |
| 9.00   | PHYSI CAL THERAPY             | 66.00     |                  | 14               | 0              |                | 9. 00  |
| 10.00  | ELECTROCARDI OLOGY            | 69.00     |                  | 933              | o o            |                | 10.00  |
| 11.00  | CARDI OPULMONARY              | 76.00     |                  | 3, 458           | ol ol          |                | 11.00  |
| 12. 00 | CLINIC                        | 90.00     | •                | 1, 145           |                |                | 12. 00 |
| 13. 00 | EMERGENCY                     | 91.00     |                  | 11, 305          |                |                | 13. 00 |
| 14. 00 | PHYSICIANS' PRIVATE OFFICES   | 192. 00   |                  | 22               | 1              |                | 14. 00 |
| 00     | 0                             |           |                  | 1, 678, 056      |                |                | 1 00   |
|        | C - MEDICAL SUPPLIES AND REBA | TFS.      | 9                | 1,070,000        | 1              |                | 1      |
| 1.00   | ADMINISTRATIVE & GENERAL      | 5. 00     |                  | 911              | 0              |                | 1. 00  |
| 2.00   | OPERATION OF PLANT            | 7. 00     | 1                | 23, 808          |                |                | 2. 00  |
| 3.00   | HOUSEKEEPI NG                 | 9. 00     | 1                | 24, 209          | 1              |                | 3.00   |
| 4. 00  | DI ETARY                      | 10. 00    |                  | 4, 099           |                |                | 4. 00  |
| 5.00   | NURSING ADMINISTRATION        | 13. 00    |                  | 4, 099<br>282    |                |                | 5. 00  |
|        |                               |           |                  |                  | 1              |                | 1      |
| 6.00   | PHARMACY                      | 15. 00    |                  | 16, 732          |                |                | 6. 00  |
| 7.00   | ADULTS & PEDIATRICS           | 30.00     |                  | 71, 026          |                |                | 7. 00  |
| 8.00   | OPERATING ROOM                | 50.00     |                  | 134, 821         |                |                | 8. 00  |
| 9. 00  | RADI OLOGY-DI AGNOSTI C       | 54.00     |                  | 2, 295           |                |                | 9. 00  |
| 10. 00 | RADI OLOGY-THERAPEUTI C       | 55. 00    |                  | 618              |                |                | 10.00  |
| 11. 00 | ULTRA SOUND                   | 56. 00    |                  | 3, 753           |                |                | 11. 00 |
| 12.00  | CT SCAN                       | 57. 00    |                  | 48, 918          |                |                | 12. 00 |
| 13. 00 | MAGNETIC RESONANCE IMAGING    | 58. 00    |                  | 6, 675           | 0              |                | 13. 00 |
|        | (MRI)                         |           |                  |                  |                |                |        |
| 14. 00 | PHYSI CAL THERAPY             | 66. 00    |                  | 7, 782           |                |                | 14. 00 |
| 15. 00 | OCCUPATI ONAL THERAPY         | 67. 00    |                  | 377              | 1              |                | 15. 00 |
| 16. 00 | ELECTROCARDI OLOGY            | 69. 00    |                  | 6, 058           |                |                | 16. 00 |
| 17. 00 | CARDI OPULMONARY              | 76.00     |                  | 17, 802          | 0              |                | 17. 00 |
| 18.00  | CLINIC                        | 90.00     |                  | 6, 611           | 0              |                | 18. 00 |
| 19.00  | EMERGENCY                     | 91.00     |                  | 164, 378         | 0              |                | 19. 00 |
| 20.00  | PHYSICIANS' PRIVATE OFFICES   | 192.00    |                  | 1, 515           | 0              |                | 20.00  |
|        | 0                             |           | 0                | 542, 670         |                |                |        |
|        | D - LAUNDRY                   |           |                  |                  |                |                |        |
| 1.00   | HOUSEKEEPI NG                 | 9.00      | 0                | 59, 229          | 0              |                | 1. 00  |
| 2.00   | DI ETARY                      | 10.00     | 0                | 6, 109           | 0              |                | 2. 00  |
|        | 0                             |           | 0                | 65, 338          | 3              |                |        |
|        | E - DEPRECIATION              |           |                  |                  |                |                |        |
| 1.00   | CAP REL COSTS-BLDG & FIXT     | 1. 00     |                  | 781, 583         | 9              |                | 1. 00  |
| 2.00   | EMPLOYEE BENEFITS DEPARTMENT  | 4.00      |                  | 1, 414           | 9              |                | 2. 00  |
| 3.00   | ADMINISTRATIVE & GENERAL      | 5.00      |                  | 18, 619          | o              |                | 3.00   |
| 4.00   | OPERATION OF PLANT            | 7.00      |                  | 12, 459          | o              |                | 4. 00  |
| 5.00   | DI ETARY                      | 10.00     |                  | 55, 560          |                |                | 5. 00  |
| 6.00   | CENTRAL SERVICES & SUPPLY     | 14.00     |                  | 5, 345           |                |                | 6. 00  |
| 7.00   | PHARMACY                      | 15. 00    |                  | 39, 387          |                |                | 7. 00  |
| 8.00   | ADULTS & PEDIATRICS           | 30.00     |                  | 43, 185          | 1              |                | 8. 00  |
| 9. 00  | OPERATING ROOM                | 50.00     |                  | 152, 063         |                |                | 9. 00  |
| 10. 00 | RADI OLOGY-DI AGNOSTI C       | 54.00     |                  | 197, 300         |                |                | 10.00  |
| 11. 00 | RADI OLOGY-THERAPEUTI C       | 55.00     |                  | 16, 852          |                |                | 11. 00 |
| 12. 00 | ULTRA SOUND                   | 56.00     | •                | 62, 138          | 1              |                | 12. 00 |
| 13. 00 | CT SCAN                       | 57.00     | •                | 87, 824          |                |                | 13. 00 |
| 14. 00 | MAGNETIC RESONANCE I MAGING   | 58.00     |                  | 143, 077         |                |                | 14. 00 |
| 14.00  |                               | 30.00     |                  | 143, 0//         | ١              |                | 14.00  |
| 15. 00 | (MRI)                         | 66.00     | -                | 2 420            |                |                | 15 00  |
|        | PHYSICAL THERAPY              |           |                  | 2, 428           |                |                | 15.00  |
| 16.00  | OCCUPATI ONAL THERAPY         | 67.00     | -                | 120              |                |                | 16.00  |
| 17. 00 | ELECTROCARDI OLOGY            | 69.00     |                  | 4, 006           | 1              |                | 17. 00 |
| 18.00  | CARDI OPULMONARY              | 76.00     |                  | 1, 216           |                |                | 18.00  |
| 19. 00 | CLI NI C                      | 90.00     | -                | 29               |                |                | 19. 00 |
| 20.00  | EMERGENCY                     | 91.00     |                  | 56, 075          |                |                | 20.00  |
| 21. 00 | PHYSICIANS' PRIVATE OFFICES   | 192.00    |                  | 2, 682           |                |                | 21. 00 |
| 22. 00 | MOB                           | 192.02    |                  | <u>253, 366</u>  |                |                | 22. 00 |
|        | 0                             |           | 0                | 1, 936, 728      | 5              |                | I      |
|        |                               |           |                  |                  |                |                |        |

RECLASSIFICATIONS

Provider CCN: 15-1312

Peri od: Worksheet A-6 From 01/01/2017

Date/Time Prepared:

500.00

12/31/2017

5/25/2018 5: 20 pm Decreases Cost Center Li ne # Sal ary 0ther Wkst. A-7 Ref. 6.00 7.00 8.00 9.00 10.00 - OTHER CAPITAL EXPENSES 1.00 CAP REL COSTS-BLDG & FIXT 1.00 1, 088, 244 11 1.00 CAP REL COSTS-BLDG & FIXT 2.00 1.00 0 24, 337 12 2.00 CAP REL COSTS-BLDG & FIXT -1.01 0 13 3.00 650 3.00 HOSPI TAL 4.00 MOB 192.02 29, 746 13 4.00 1, 142, 977 G - OPERATION OF PLANT OPERATION OF PLANT 7 00 1.00 0 1, 498, 126 0 1.00 2.00 192.02 264, 338 0 2.00 ō 1, 762, 464 H - EMPLOYEE BENEFITS 1.00 ADMINISTRATIVE & GENERAL 5.00 0 122, 466 0 1.00 2.00 OPERATION OF PLANT 7.00 0 50, 061 0 2.00 HOUSEKEEPI NG 9.00 0 112, 769 0 3.00 3.00 0 DI ETARY 10.00 133.752 4.00 4.00 5.00 NURSING ADMINISTRATION 13.00 0 129, 608 0 5.00 PHARMACY 15.00 0 37, 277 0 6.00 6.00 0 0 ADULTS & PEDIATRICS 30.00 7.00 227, 976 7.00 OPERATING ROOM 50.00 0 8.00 88.754 8 00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 63, 628 0 9.00 RADI OLOGY-THERAPEUTI C 0 0 10.00 55.00 13, 945 10.00 ULTRA SOUND 0 0 12, 803 11.00 56.00 11.00 12.00 CT SCAN 57.00 64, 583 12.00 13.00 MAGNETIC RESONANCE IMAGING 58.00 0 26, 515 0 13.00 (MRI) 14 00 PHYSICAL THERAPY 66 00 0 62, 580 0 14.00 OCCUPATIONAL THERAPY 0 0 15.00 67.00 15, 524 15.00 16.00 SPEECH PATHOLOGY 68.00 0 13, 907 0 16.00 ELECTROCARDI OLOGY o 0 17.00 69.00 14, 285 17.00 CARDI OPULMONARY 0 18 00 76 00 88, 127 0 18 00 0 19.00 CLINIC 90.00 26, 423 0 19.00 20.00 EMERGENCY 91.00 0 142, 894 0 20.00 192.00 21.00 PHYSICIANS' PRIVATE OFFICES 0 13, 457 0 21.00 1, 461, 334 HOUSEKEEPING SUPPLIES 1.00 DI ETARY 10.00 0 1.00 6, 101 0 2.00 PHARMACY 15.00 0 981 2.00 ADULTS & PEDIATRICS 30.00 0 0 3.00 213 3.00 4.00 OPERATING ROOM 50.00 0 0 4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 0 51 0 5.00 ULTRA SOUND 0 0 6.00 56, 00 88 6.00 MAGNETIC RESONANCE IMAGING 0 7.00 58.00 8 7.00 (MRI) 8.00 ELECTROCARDI OLOGY 69.00 o 0 8.00 9.00 CLINIC 90.00 0 17 0 9.00 EMERGENCY 10.00 91.00 22 0 10.00 7, 490 J - NON-CAPITAL EXPENSES CAP REL COSTS-BLDG & FIXT 1.00 1 00 121 367 12 1 00 T0TALS 121, 367

72, 568

8, 746, 130

500.00 Grand Total: Decreases

| Period: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:

|  |                  |             | To              | 12/31/2017 | Date/Time Pre 5/25/2018 5: 2 |                 |
|--|------------------|-------------|-----------------|------------|------------------------------|-----------------|
|  |                  |             | Acqui si ti ons |            | 372372010 3.2                | Э ріп           |
|  | Begi nni ng      | Purchases   | Donati on       | Total      | Di sposal s and              |                 |
|  | Bal ances        |             |                 |            | Retirements                  |                 |
|  | 1.00             | 2.00        | 3.00            | 4. 00      | 5. 00                        |                 |
| PART I - ANALYSIS OF CHANGES IN                          |                  |             |                 |            |                              |                 |
| 1.00 Land  | 954, 570         | 0           | 0               | 0          | 0                            | 1. 00           |
| 2.00 Land Improvements                                   | 1, 236, 020      | 0           | 0               | 0          | 189, 940                     | 2.00            |
| 3.00 Buildings and Fixtures                              | 0                | 0           | 0               | 0          | 0                            | 3.00            |
| 4.00 Building Improvements                               | 40, 472, 821     | 89, 534     | 0               | 89, 534    | 165, 773                     | 4.00            |
| 5.00 Fixed Equipment                                     | 0                | 0           | 0               | 0          | 0                            | 5. 00           |
| 6.00 Movable Equipment                                   | 4, 883, 424      | 229, 357    | 0               | 229, 357   | 43, 506                      | 6.00            |
| 7.00 HIT designated Assets                               | 15, 000          | 0           | 0               | 0          | 0                            | 7. 00           |
| 8.00 Subtotal (sum of lines 1-7)                         | 47, 561, 835     | 318, 891    | 0               | 318, 891   | 399, 219                     | 8. 00           |
| 9.00 Reconciling Items                                   | 0                | 0           | 0               | 0          | 0                            | 9. 00           |
| 10.00 Total (line 8 minus line 9)                        | 47, 561, 835     | 318, 891    | 0               | 318, 891   | 399, 219                     | 10. 00          |
|  | Endi ng Bal ance | Fully       |                 |            |                              |                 |
|  |                  | Depreciated |                 |            |                              |                 |
|  | ( 00             | Assets      |                 |            |                              |                 |
| DART I ANALYGIC OF GUANGEC IA                            | 6.00             | 7. 00       |                 |            |                              |                 |
| PART I - ANALYSIS OF CHANGES IN                          |                  |             |                 |            |                              | 1 00            |
| 1. 00 Land   | 954, 570         | 0           |                 |            |                              | 1.00            |
| 2.00 Land Improvements                                   | 1, 046, 080      | 0           |                 |            |                              | 2.00            |
| 3.00 Buildings and Fixtures                              | 40, 204, 502     | 0           |                 |            |                              | 3.00            |
| 4.00 Building Improvements                               | 40, 396, 582     | 0           |                 |            |                              | 4. 00           |
| 5. 00 Fi xed Equipment                                   | U<br>5 0/0 275   | 404 (7)     |                 |            |                              | 5. 00           |
| 6.00 Movable Equipment                                   | 5, 069, 275      | 494, 676    |                 |            |                              | 6. 00           |
| 7.00 HIT designated Assets                               | 15, 000          | 15, 000     |                 |            |                              | 7. 00           |
| 8.00 Subtotal (sum of lines 1-7) 9.00 Reconciling Items  | 47, 481, 507     | 509, 676    |                 |            |                              | 8. 00<br>9. 00  |
| 9.00 Reconciling Items 10.00 Total (line 8 minus line 9) | 47, 481, 507     | 509, 676    |                 |            |                              | 9. 00<br>10. 00 |
| 10.00   Total (True 8 militus True 9)                    | 47, 481, 507     | 209, 676    |                 |            |                              | 10.00           |

| Health Financial Systems                | IU HEALTH WHITE HOSPITAL | In Lieu of Form CMS-2552-10   |
|---|--------------------------|---|
| RECONCILIATION OF CAPITAL COSTS CENTERS | Provi der CCN: 15-1312   | Peri od:<br>From 01/01/2017<br>To 12/31/2017 Date/Time Prepared:<br>5/25/2018 5:20 pm |

|  |                  |                | Т               | To 12/31/2017                | Date/Time Pre 5/25/2018 5:2 |       |
|--|------------------|----------------|-----------------|------------------------------|-----------------------------|-------|
|  |                  | SL             | JMMARY OF CAPIT | ΓAL                          |                             |       |
| Cost Center Description                      | Depreci ati on   | Lease          | Interest        | Insurance (see instructions) | ,                           |       |
|  | 9. 00            | 10.00          | 11. 00          | 12.00                        | 13. 00                      |       |
| PART II - RECONCILIATION OF AMOUNTS FROM WO  | RKSHEET A, COLUN | N 2, LINES 1 a | nd 2            |                              |                             |       |
| 1.00 CAP REL COSTS-BLDG & FLXT               | 793, 161         | 0              | 1, 088, 244     | 145, 687                     | 0                           | 1. 00 |
| 1.01 CAP REL COSTS-BLDG & FLXT - HOSPITAL    | 0                | 0              | C               | 0                            | 0                           | 1. 01 |
| 1.02 CAP REL COSTS-BLDG & FIXT - TLMOB       | 0                | 0              | C               | 0                            | 0                           | 1. 02 |
| 3.00   Total (sum of lines 1-2)              | 793, 161         |                | 1, 088, 244     | 145, 687                     | 0                           | 3. 00 |
| SUMMARY OF CAPITAL                           |                  |                |                 |                              |                             |       |
| Cost Center Description                      | Other            | Total (1) (sum |                 |                              |                             |       |
|  | Capi tal -Relate |                |                 |                              |                             |       |
|  | d Costs (see     | through 14)    |                 |                              |                             |       |
|  | instructions)    |                |                 |                              |                             |       |
|  | 14.00            | 15.00          | L               |                              |                             |       |
| PART II - RECONCILIATION OF AMOUNTS FROM WOL |                  | <del> </del>   |                 |                              |                             |       |
| 1. 00 CAP REL COSTS-BLDG & FLXT              | 17               | 2, 027, 109    |                 |                              |                             | 1. 00 |
| 1. 01 CAP REL COSTS-BLDG & FIXT - HOSPITAL   | 0                | 0              |                 |                              |                             | 1. 01 |
| 1. 02 CAP REL COSTS-BLDG & FIXT - TLMOB      | 0                | 0              |                 |                              |                             | 1. 02 |
| 3.00  Total (sum of lines 1-2)               | 17               | 2, 027, 109    | 1               |                              |                             | 3. 00 |

| Heal th | Financial Systems  | IU HEALTH WHI       | TE HOSPITAL              |  | In Lie                                      | u of Form CMS-2 | 552-10 |
|---------|--|---------------------|--------------------------|--|---|-----------------|--------|
|         | CILIATION OF CAPITAL COSTS CENTERS   |                     | Provi der C              |  | Period:<br>From 01/01/2017<br>To 12/31/2017 | 5/25/2018 5: 20 |        |
|         |  | COMF                | PUTATION OF RAT          | TI OS  | ALLOCATION OF                               | OTHER CAPITAL   |        |
|         | Cost Center Description  | Gross Assets        | Capi tal i zed<br>Leases | Gross Assets<br>for Ratio<br>(col. 1 - col<br>2) | instructions)                               | Insurance       |        |
|         |  | 1. 00               | 2. 00                    | 3.00   | 4. 00                                       | 5. 00           |        |
|         | PART III - RECONCILIATION OF CAPITAL COSTS CE                              |                     |                          |  |   |                 |        |
| 1.00    | CAP REL COSTS-BLDG & FLXT  | 2, 000, 650         |                          | _, -,,   |   |                 | 1.00   |
| 1.01    | CAP REL COSTS-BLDG & FIXT - HOSPITAL                                       | 30, 010, 686        |                          | 30, 010, 68                                      |   |                 | 1. 01  |
| 1.02    | CAP REL COSTS-BLDG & FIXT - TLMOB  | 15, 470, 173        |                          | 15, 470, 17                                      |   |                 | 1. 02  |
| 3.00    | Total (sum of lines 1-2)   | 47, 481, 509        |                          | 47, 481, 50                                      |   |                 | 3. 00  |
|         |  | ALLOCA <sup>-</sup> | TION OF OTHER (          | CAPI TAL   | SUMMARY O                                   | F CAPITAL       |        |
|         | Cost Center Description  | Taxes               | 0ther                    | Total (sum of                                    | Depreciation                                | Lease           |        |
|         |  |                     | Capi tal -Relate         |  |   |                 |        |
|         |  | / 00                | d Costs                  | through 7)                                       | 0.00  | 10.00           |        |
|         | DART III DECONCILIATION OF CARLTAL COSTS OF                                | 6. 00               | 7. 00                    | 8.00   | 9. 00                                       | 10.00           |        |
| 1. 00   | PART III - RECONCILIATION OF CAPITAL COSTS CE<br>CAP REL COSTS-BLDG & FIXT | INTERS              | 0                        |  | 0 66, 249                                   | 0               | 1. 00  |
| 1.00    | CAP REL COSTS-BLDG & FIXT - HOSPITAL                                       | 0                   | 0                        |  | 1, 853, 206                                 | 0               | 1. 00  |
| 1.01    | CAP REL COSTS-BLDG & FIXT - TLMOB  | 0                   | 0                        | 1  | 0 613, 009                                  |                 | 1. 01  |
| 3.00    | Total (sum of lines 1-2)   | 0                   | 0                        |  | 2, 532, 464                                 | 0               | 3. 00  |
| 3.00    | Total (Suil of Titles 1-2)   | U                   | SI SI                    | I<br>JMMARY OF CAPI                              |   | U               | 3.00   |
|         |  |                     | 30                       | DIVINIANT OF CALL                                | IAL   |                 |        |
|         | Cost Center Description  | Interest            | Insurance (see           | Taxes (see                                       | Other                                       | Total (2) (sum  |        |
|         |  |                     |                          |  | Capi tal -Rel ate                           |                 |        |
|         |  |                     | ,                        | ĺ  | d Costs (see                                | through 14)     |        |
|         |  |                     |                          |  | instructions)                               | , ,             |        |
|         |  | 11. 00              | 12.00                    | 13.00  | 14.00                                       | 15.00           |        |
|         | PART III - RECONCILIATION OF CAPITAL COSTS CE                              |                     |                          |  |   |                 |        |
| 1.00    | CAP REL COSTS-BLDG & FIXT  | 30, 924             | -17                      |  | 0 17  | 97, 173         | 1.00   |
| 1.01    | CAP REL COSTS-BLDG & FIXT - HOSPITAL                                       | 1, 127, 014         | 24, 337                  | -65  | 0 0   | 3, 003, 907     | 1. 01  |
| 1.02    | CAP REL COSTS-BLDG & FIXT - TLMOB  | 0                   | 0                        | 29, 74   | 6 0   | 642, 755        | 1. 02  |
| 3.00    | Total (sum of lines 1-2)   | 1, 157, 938         | 24, 320                  | 29, 09   | 6 17  | 3, 743, 835     | 3. 00  |
|         |  |                     |                          |  |   |                 |        |

| Period: | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1312

|                     |   |                |               | To                                      | 12/31/2017      | Date/Time Prep<br>5/25/2018 5:20 |                  |
|---------------------|---|----------------|---------------|---|-----------------|----------------------------------|------------------|
|                     |   |                |               | Expense Classification on               |                 |                                  | у риг            |
|                     |   |                |               | To/From Which the Amount is             | to be Adjusted  |                                  |                  |
|                     |   |                |               |   |                 |                                  |                  |
|                     | Cost Center Description   | Pasis/Codo (2) | Amount        | Cost Center                             | Li ne #         | Wkst. A-7 Ref.                   |                  |
|                     |   | 1.00           | 2. 00         | 3.00                                    | 4. 00           | 5. 00                            |                  |
| 1. 00               | Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)                               |                | 0             | CAP REL COSTS-BLDG & FLXT               | 1. 00           | 0                                | 1. 00            |
| 1. 01               | Investment income - CAP REL<br>COSTS-BLDG & FIXT - HOSPITAL<br>(chapter 2)              | В              | -41, 910      | CAP REL COSTS-BLDG & FIXT -<br>HOSPITAL | 1. 01           | 11                               | 1. 01            |
| 1. 02               | Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB                                   |                | 0             | CAP REL COSTS-BLDG & FIXT -<br>TLMOB    | 1. 02           | 0                                | 1. 02            |
| 2.00                | (chapter 2) Investment income - CAP REL   |                | 0             | *** Cost Center Deleted ***             | 2. 00           | 0                                | 2. 00            |
| 3. 00               | COSTS-MVBLE EQUIP (chapter 2) Investment income - other                                 |                | 0             |   | 0. 00           | 0                                | 3. 00            |
| 4. 00               | (chapter 2) Trade, quantity, and time   |                | 0             |   | 0. 00           | 0                                | 4. 00            |
| 5. 00               | discounts (chapter 8)<br>Refunds and rebates of   |                | 0             |   | 0. 00           | 0                                | 5. 00            |
| 6. 00               | expenses (chapter 8) Rental of provider space by  |                | 0             |   | 0. 00           | 0                                | 6. 00            |
| 7.00                | suppliers (chapter 8) Telephone services (pay   |                | 0             |   | 0. 00           | 0                                | 7. 00            |
|                     | stations excluded) (chapter 21)   |                |               |   |                 |                                  |                  |
| 8. 00               | Television and radio service (chapter 21)   |                | 0             |   | 0. 00           | 0                                | 8. 00            |
| 9. 00<br>10. 00     | Parking Lot (chapter 21) Provider-based physician                                       | A-8-2          | -360, 347     |   | 0. 00           | 0                                | 9. 00<br>10. 00  |
| 11. 00              | adjustment<br>Sale of scrap, waste, etc.  |                | 0             |   | 0. 00           | 0                                | 11. 00           |
| 12. 00              | (chapter 23) Related organization   | A-8-1          | 1, 682, 866   |   |                 | 0                                | 12. 00           |
| 13. 00              | transactions (chapter 10) Laundry and linen service                                     |                | 0             |   | 0. 00           | 0                                | 13. 00           |
| 14. 00<br>15. 00    | Cafeteria-employees and guests<br>Rental of quarters to employee                        |                | -46, 012<br>0 | CAFETERI A                              | 11. 00<br>0. 00 | 0                                | 14. 00<br>15. 00 |
| 16. 00              | and others Sale of medical and surgical   |                | 0             |   | 0.00            | 0                                |                  |
| 10.00               | supplies to other than patients   |                | O             |   | 0.00            | Ŭ                                | 10.00            |
| 17. 00              | Sale of drugs to other than patients  |                | 0             |   | 0. 00           | 0                                | 17. 00           |
| 18. 00              | Sale of medical records and abstracts   |                | 0             |   | 0. 00           | 0                                | 18. 00           |
| 19. 00              | Nursing and allied health education (tuition, fees,                                     |                | 0             |   | 0. 00           | 0                                | 19. 00           |
| 20. 00              | books, etc.)<br>Vending machines  |                | 0             |   | 0.00            | 0                                | 20. 00           |
| 21. 00              | Income from imposition of interest, finance or penalty charges (chapter 21)             |                | 0             |   | 0. 00           | 0                                | 21. 00           |
| 22. 00              | Interest expense on Medicare overpayments and borrowings to                             |                | 0             |   | 0. 00           | 0                                | 22. 00           |
| 23. 00              | repay Medicare overpayments<br>Adjustment for respiratory<br>therapy costs in excess of | A-8-3          | 0             | *** Cost Center Deleted ***             | 65. 00          |                                  | 23. 00           |
| 24. 00              | limitation (chapter 14) Adjustment for physical therapy costs in excess of              | A-8-3          | 0             | PHYSICAL THERAPY                        | 66. 00          |                                  | 24. 00           |
| 25. 00              | limitation (chapter 14) Utilization review - physicians' compensation                   |                | 0             | *** Cost Center Deleted ***             | 114. 00         |                                  | 25. 00           |
| 26. 00              | (chapter 21)   Depreciation - CAP REL   | A              | 54, 671       | CAP REL COSTS-BLDG & FIXT               | 1. 00           | 9                                | 26. 00           |
| 26. 01              | COSTS-BLDG & FIXT Depreciation - CAP REL  | A              | 106, 753      | CAP REL COSTS-BLDG & FIXT -             | 1. 01           | 9                                | 26. 01           |
| 26. 02              | COSTS-BLDG & FIXT - HOSPITAL  Depreciation - CAP REL                                    | A              | 359, 643      | HOSPITAL  CAP REL COSTS-BLDG & FIXT -   | 1. 02           | 9                                | 26. 02           |
| 27. 00              | COSTS-BLDG & FIXT - TLMOB Depreciation - CAP REL  |                | 0             | TLMOB *** Cost Center Deleted ***       | 2. 00           | 0                                | 27. 00           |
| 28. 00<br>29. 00    | COSTS-MVBLE EQUIP Non-physician Anesthetist   |                | 0             | *** Cost Center Deleted ***             | 19. 00<br>0. 00 |                                  | 28. 00           |
| ∠ <del>9</del> . UU | Physi ci ans' assi stant  |                | 0             | 1                                       | 0.00            | 미                                | 29. 00           |

|        |                                |                |              | To                             | 12/31/2017     |                |        |
|--------|--------------------------------|----------------|--------------|--------------------------------|----------------|----------------|--------|
|        |                                |                |              | Expense Classification on      | Waskahaa+ A    | 5/25/2018 5: 2 | U pm   |
|        |                                |                |              | To/From Which the Amount is    |                |                |        |
|        |                                |                |              | TO/FI OIII WITCH THE AMOUNT IS | to be Aujusteu |                |        |
|        |                                |                |              |                                |                |                |        |
|        |                                |                |              |                                |                |                |        |
|        |                                |                |              |                                |                |                |        |
|        | Cost Center Description        | Basis/Code (2) | Amount       | Cost Center                    | Li ne #        | Wkst. A-7 Ref. |        |
|        | cost center bescription        | 1.00           | 2.00         | 3.00                           | 4. 00          | 5. 00          |        |
| 30. 00 | Adjustment for occupational    | A-8-3          |              | OCCUPATI ONAL THERAPY          | 67.00          |                | 30.00  |
| 30.00  | therapy costs in excess of     | 7 0 3          | 0            | OCCONTATIONAL THERAIT          | 07.00          |                | 30.00  |
|        | limitation (chapter 14)        |                |              |                                |                |                |        |
| 30. 99 | Hospice (non-distinct) (see    |                | 0            | ADULTS & PEDIATRICS            | 30.00          |                | 30. 99 |
| 00. 77 | instructions)                  |                | O            | ABOETS & LEBIATRI 03           | 00.00          |                | 00. 77 |
| 31. 00 | Adjustment for speech          | A-8-3          | 0            | SPEECH PATHOLOGY               | 68.00          |                | 31. 00 |
| 01.00  | pathology costs in excess of   |                | · ·          | 0. 220.1 17111102001           | 00.00          |                | 000    |
|        | limitation (chapter 14)        |                |              |                                |                |                |        |
| 32. 00 | CAH HIT Adjustment for         | A              | -34, 437     | CAP REL COSTS-BLDG & FIXT -    | 1. 01          | 9              | 32. 00 |
|        | Depreciation and Interest      |                |              | HOSPI TAL                      |                |                |        |
| 33.00  | EMPLOYEE BENEFITS              | A              | -1, 461, 334 | EMPLOYEE BENEFITS DEPARTMENT   | 4.00           | 0              | 33. 00 |
| 33. 01 | UNWONTED SITUATIONS            | A              | -420         | OPERATING ROOM                 | 50.00          | 0              | 33. 01 |
| 33. 02 | MARKETI NG                     | A              | -273         | ADMINISTRATIVE & GENERAL       | 5. 00          | 0              | 33. 02 |
| 33. 03 | MARKETI NG                     | A              |              | NURSING ADMINISTRATION         | 13. 00         |                | 1      |
| 33. 06 | LOSS ON ABANDONMENT            | l A            |              | CAP REL COSTS-BLDG & FIXT -    | 1. 01          | 9              | 1      |
|        |                                |                | , , ,        | HOSPI TAL                      |                |                |        |
| 33. 07 | CATERING / OTHER REVENUE       | В              | -43, 921     | CAFETERI A                     | 11. 00         | 0              | 33. 07 |
| 33. 08 | MEDICALD HAF FEES              | A              | -813, 374    | ADMINISTRATIVE & GENERAL       | 5. 00          | 0              | 33. 08 |
| 33. 09 | MI SCELLANEOUS I NCOME         | В              | -5, 467      | ADMINISTRATIVE & GENERAL       | 5. 00          | 0              | 33. 09 |
| 33. 10 | MI SCELLANEOUS I NCOME         | В              | -6, 065      | NURSING ADMINISTRATION         | 13.00          | 0              | 33. 10 |
| 33. 11 | MI SCELLANEOUS I NCOME         | В              | -11, 038     | CENTRAL SERVICES & SUPPLY      | 14.00          | 0              | 33. 11 |
| 33. 12 | MI SCELLANEOUS I NCOME         | В              |              | PHARMACY                       | 15. 00         |                | 33. 12 |
| 33. 13 | II                             | В              |              | RADI OLOGY-DI AGNOSTI C        | 54.00          |                | 33. 13 |
| 33. 14 | WIC PROGRAM COSTS              | l A            | -193, 843    |                                | 10.00          |                | 33. 14 |
| 33. 15 | WIC PROGRAM BENEFIT COSTS      | l A            |              | EMPLOYEE BENEFITS DEPARTMENT   | 4. 00          |                | 33. 15 |
| 33. 16 | CRNA COSTS                     | l A            | · ·          | OPERATING ROOM                 | 50.00          | 0              | 33, 16 |
| 33. 17 | ACCRUED PTO - GENERAL          | l A            | · ·          | ADMINISTRATIVE & GENERAL       | 5. 00          | 0              | 33. 17 |
| 33. 18 | CONTRIBUTION EXPENSE           | l A            | · ·          | ADMINISTRATIVE & GENERAL       | 5. 00          |                | 33. 18 |
| 33. 19 | TELEPHONE EXPENSE              | A              |              | RADI OLOGY-THERAPEUTI C        | 55. 00         |                |        |
| 50. 00 | TOTAL (sum of lines 1 thru 49) |                | -952, 008    |                                |                |                | 50.00  |
|        | (Transfer to Worksheet A,      |                | , 000        |                                |                |                |        |
|        | column 6, line 200.)           |                |              |                                |                |                |        |

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

Note: See instructions for column 5 referencing to Worksheet A-7.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-1312

Peri od: Worksheet A-8-1 From 01/01/2017

| 002   | 555.5                         |                               |                              | To 12/31/2017   | Date/Time Pre 5/25/2018 5:2 |       |
|-------|-------------------------------|-------------------------------|------------------------------|-----------------|-----------------------------|-------|
|       | Li ne No.                     | Cost Center                   | Expense Items                | Amount of       | Amount                      | •     |
|       |                               |                               | ·                            | Allowable Cost  | Included in                 |       |
|       |                               |                               |                              |                 | Wks. A, column              |       |
|       |                               |                               |                              |                 | 5                           |       |
|       | 1. 00                         | 2. 00                         | 3. 00                        | 4. 00           | 5. 00                       |       |
|       | A. COSTS INCURRED AND ADJUSTM | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED OF | RGANIZATIONS OR | CLAIMED                     |       |
|       | HOME OFFICE COSTS:            | 0.45 BEL 000TO BLDG 4 ELVT    | LIGHT OFFI OF ALL COATION    | 1 400 (04)      | 1 222 211                   |       |
| 1.00  |                               |                               | HOME OFFICE ALLOCATION       | 1, 122, 681     | 1, 088, 244                 | 1. 00 |
| 2.00  |                               |                               | HOME OFFICE ALLOCATION       | 1, 131, 142     | 0                           | 2. 00 |
| 3.00  |                               |                               | HOME OFFICE ALLOCATION       | 2, 986, 151     | 4, 080, 523                 | 3. 00 |
| 3. 01 |                               |                               | POOLED CAPITAL - H. O.       | 105, 559        | 0                           | 3. 01 |
| 3.02  |                               |                               | HOME OFFICE ALLOCATION       | 0               | 29, 806                     | 3. 02 |
| 4.00  |                               |                               | RELATED PARTY                | 30, 924         | 0                           | 4. 00 |
| 4. 01 |                               |                               | RELATED PARTY                | 46, 243         | 0                           | 4. 01 |
| 4.02  |                               |                               | RELATED PARTY                | 89, 779         | 0                           | 4. 02 |
| 4. 03 |                               |                               | RELATED PARTY                | 915, 922        | 143, 754                    | 4. 03 |
| 4.04  |                               |                               | RELATED PARTY                | 37, 041         | 0                           | 4. 04 |
| 4.05  |                               | OPERATION OF PLANT - HOSPITA  |                              | 80, 927         | 0                           | 4. 05 |
| 4.06  |                               |                               | RELATED PARTY                | 18, 881         | 0                           | 4. 06 |
| 4. 07 |                               |                               | RELATED PARTY                | 5, 639          | 0                           | 4. 07 |
| 4. 08 |                               |                               | RELATED PARTY                | 155, 712        | 0                           | 4. 08 |
| 4.09  |                               |                               | RELATED PARTY                | 184, 627        | 153, 018                    | 4. 09 |
| 4. 10 |                               |                               | RELATED PARTY                | 367, 031        | 203, 287                    | 4. 10 |
| 4. 11 |                               |                               | RELATED PARTY                | 1, 151, 681     | 1, 151, 681                 | 4. 11 |
| 4. 12 |                               |                               | RELATED PARTY                | 11, 973         | 11, 973                     | 4. 12 |
| 4. 13 |                               |                               | RELATED PARTY                | 78, 578         | 62, 400                     | 4. 13 |
| 4.14  |                               |                               | RELATED PARTY                | 87, 061         | 0                           | 4. 14 |
| 4. 15 |                               | PHYSICIANS' PRIVATE OFFICES   | RELATED PARTY                | 24, 960         | 24, 960                     | 4. 15 |
| 5.00  | TOTALS (sum of lines 1-4).    |                               |                              | 8, 632, 512     | 6, 949, 646                 | 5. 00 |
|       | Transfer column 6, line 5 to  |                               |                              |                 |                             |       |
|       | Worksheet A-8, column 2,      |                               |                              |                 |                             |       |
|       | line 12.                      |                               |                              |                 |                             |       |

\* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

| •                             |                               |               |                              |                |  |
|-------------------------------|-------------------------------|---------------|------------------------------|----------------|--|
|                               |                               |               | Related Organization(s) and/ | or Home Office |  |
|                               |                               |               | 3 , ,                        |                |  |
|                               |                               |               |                              |                |  |
|                               |                               |               |                              |                |  |
|                               |                               |               |                              |                |  |
|                               |                               |               |                              |                |  |
| Symbol (1)                    | Name                          | Percentage of | Name                         | Percentage of  |  |
| , , ,                         |                               | Ownershi p    |                              | Ownershi p     |  |
|                               |                               | Owner Sili p  |                              | Owner Sili p   |  |
| 1. 00                         | 2. 00                         | 3. 00         | 4. 00                        | 5. 00          |  |
| B. INTERRELATIONSHIP TO RELAT | TED ORGANIZATION(S) AND/OR HO | ME OFFICE:    |                              |                |  |
|                               | . ,                           |               |                              |                |  |

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

| 6.00   | В                       | IU HEALTH  | 100.00 | 0. 00 | 6. 00  |
|--------|-------------------------|------------|--------|-------|--------|
| 7.00   | В                       | IUH ARNETT | 1.00   | 0.00  | 7. 00  |
| 8.00   |                         |            | 0.00   | 0.00  | 8. 00  |
| 9.00   |                         |            | 0.00   | 0.00  | 9. 00  |
| 10.00  |                         |            | 0.00   | 0.00  | 10.00  |
| 100.00 | G. Other (financial or  |            |        |       | 100.00 |
|        | non-financial) specify: |            |        |       |        |

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

|       |                |                 | To 12/31/2017   Date/Time Pro<br>  5/25/2018 5:2                                 |         |
|-------|----------------|-----------------|--|---------|
|       | Net            | Wkst. A-7 Ref.  |  | LO DIII |
|       | Adjustments    |                 |  |         |
|       | (col. 4 minus  |                 |  |         |
|       | col. 5)*       |                 |  |         |
|       | 6. 00          | 7. 00           |  |         |
|       | A. COSTS INCUR | RED AND ADJUSTN | MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED |         |
|       | HOME OFFICE CO |                 |  |         |
| 1. 00 | 34, 437        |                 |  | 1.00    |
| 2.00  | 1, 131, 142    |                 |  | 2.00    |
| 3.00  | -1, 094, 372   |                 |  | 3.00    |
| 3. 01 | 105, 559       |                 |  | 3. 01   |
| 3. 02 | -29, 806       |                 |  | 3. 02   |
| 4.00  | 30, 924        |                 |  | 4.00    |
| 4. 01 | 46, 243        |                 |  | 4. 01   |
| 4. 02 | 89, 779        |                 |  | 4. 02   |
| 4.03  | 772, 168       |                 |  | 4. 03   |
| 4.04  | 37, 041        |                 |  | 4. 04   |
| 4. 05 | 80, 927        |                 |  | 4. 05   |
| 4.06  | 18, 881        |                 |  | 4.06    |
| 4. 07 | 5, 639         |                 |  | 4. 07   |
| 4. 08 | 155, 712       |                 |  | 4. 08   |
| 4. 09 | 31, 609        |                 |  | 4. 09   |
| 4. 10 | 163, 744       | 1               |  | 4. 10   |
| 4. 11 | 0              | 0               |  | 4. 11   |
| 4. 12 | 0              | 0               |  | 4. 12   |
| 4. 13 | 16, 178        |                 |  | 4. 13   |
| 4. 14 | 87, 061        |                 |  | 4. 14   |
| 4. 15 |                |                 |  | 4. 15   |
| 5.00  | 1, 682, 866    |                 |  | 5. 00   |

\* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

| Related Organization(s)<br>and/or Home Office |  |  |
|---|--|--|
| Type of Business                              |  |  |
| 6. 00   |  |  |
| B. INTERRELATIONSHIP TO RELAT                 | ED ORGANIZATION(S) AND/OR HOME OFFICE: |  |

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

| 6.00                       |  | 6. 00  |
|----------------------------|--|--------|
| 7. 00                      |  | 7. 00  |
| 7. 00<br>8. 00             |  | 8.00   |
| 9. 00                      |  | 9. 00  |
| 10. 00                     |  | 10.00  |
| 9. 00<br>10. 00<br>100. 00 |  | 100.00 |

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

|        |                 |                       |                |               |                  |                 | 5/25/2018 5: 2   | O pm    |
|--------|-----------------|-----------------------|----------------|---------------|------------------|-----------------|------------------|---------|
|        | Wkst. A Line #  | Cost Center/Physician | Total          | Professi onal | Provi der        | RCE Amount      | Physi ci an/Prov |         |
|        |                 | Identifier            | Remuneration   | Component     | Component        |                 | ider Component   |         |
|        |                 |                       |                | ·             | ·                |                 | Hours            |         |
|        | 1. 00           | 2. 00                 | 3.00           | 4.00          | 5. 00            | 6. 00           | 7. 00            |         |
| 1. 00  | 30.00           | ADULTS & PEDIATRICS   | 165, 355       | 165, 355      | 0                | 0               | 0                | 1. 00   |
| 2.00   | 50.00           | OPERATING ROOM        | 194, 992       | 194, 992      | 0                | 0               | 0                | 2. 00   |
| 3.00   | 91. 00          | EMERGENCY             | 850, 339       | 0             | 850, 339         | 0               | 0                | 3. 00   |
| 4.00   | 0.00            |                       | 0              | 0             |                  | l               | 0                | 4. 00   |
| 5. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               | 0                | 5. 00   |
| 6. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               | 0                | 6. 00   |
| 7. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               | 0                | 7. 00   |
| 8. 00  | 0.00            |                       | 0              | 0             | 0                | 0               | 0                | 8. 00   |
| 9. 00  | 0.00            |                       | 0              | 0             | 0                | l o             | ا م              | 9. 00   |
| 10. 00 | 0.00            |                       | 1 0            | 0             | 0                | 0               | 0                | 10. 00  |
| 200.00 | 0.00            |                       | 1, 210, 686    | 360, 347      | 850, 339         | Ĭ               | 0                |         |
| 200.00 | Wkst. A Line #  | Cost Center/Physician | Unadjusted RCE |               | Cost of          | Provi der       | Physician Cost   |         |
|        | WKSt. A LITIC # | I denti fi er         | Li mi t        |               | Memberships &    | Component       | of Malpractice   |         |
|        |                 | rueller i i ei        |                | Li mi t       | Continuing       | Share of col.   | Insurance        |         |
|        |                 |                       |                | 21 1111 0     | Education        | 12              | Trisur unce      |         |
| •      | 1. 00           | 2.00                  | 8. 00          | 9. 00         | 12. 00           | 13. 00          | 14.00            |         |
| 1. 00  |                 | ADULTS & PEDLATRICS   | 0              | 0             |                  |                 | 0                | 1. 00   |
| 2.00   | 50.00           | OPERATING ROOM        | 0              | 0             | 0                | 0               | 0                | 2. 00   |
| 3. 00  |                 | EMERGENCY             | 0              | 0             | 0                | 0               | 0                | 3. 00   |
| 4.00   | 0.00            |                       | 0              | 0             | 0                | 0               | 0                | 4. 00   |
| 5. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               | 0                | 5. 00   |
| 6. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               | 0                | 6. 00   |
| 7. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               | 0                | 7. 00   |
| 8. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               | 0                | 8. 00   |
| 9. 00  | 0.00            |                       | 0              | 0             | 0                | 0               | 0                |         |
| 10.00  | 0.00            |                       | 0              | 0             | 0                | 0               | 0                | 10. 00  |
| 200.00 | 0.00            |                       | 0              | 0             | 0                | 0               | l o              |         |
| 200.00 | Wkst. A Line #  | Cost Center/Physician | Provi der      | Adjusted RCE  | RCE              | Adjustment      | J                | 200.00  |
|        |                 | I denti fi er         | Component      | Limit         | Di sal I owance  | / raj do emorre |                  |         |
|        |                 | 1 40.1121 11 61       | Share of col.  | 2             | Di dai i dilando |                 |                  |         |
|        |                 |                       | 14             |               |                  |                 |                  |         |
|        | 1. 00           | 2. 00                 | 15. 00         | 16. 00        | 17. 00           | 18. 00          |                  |         |
| 1. 00  | 30.00           | ADULTS & PEDIATRICS   | 0              |               |                  |                 |                  | 1. 00   |
| 2.00   | 50. 00          | OPERATING ROOM        | 0              | 0             | 0                | 194, 992        |                  | 2. 00   |
| 3. 00  |                 | EMERGENCY             | 0              | 0             | 0                | 0               |                  | 3. 00   |
| 4. 00  | 0. 00           |                       | 0              | 0             | 0                | 0               |                  | 4. 00   |
| 5. 00  | 0.00            |                       | 1 0            | 0             | _                | ا م             |                  | 5. 00   |
| 6. 00  | 0.00            |                       | 1 0            | 0             |                  | 0               |                  | 6. 00   |
| 7. 00  | 0.00            |                       | 1 0            | 0             | _                | ا م             |                  | 7. 00   |
| 8. 00  | 0.00            |                       | 1 0            | 0             | _                | ١               |                  | 8. 00   |
| 9. 00  | 0.00            |                       | 0              | ١             | 0                | 1               |                  | 9. 00   |
| 10. 00 | 0.00            |                       |                | 0             | _                | 1               |                  | 10. 00  |
| 200.00 | 3.00            |                       | 1 0            | 0             |                  |                 |                  | 200. 00 |
| _00.00 | ı               |                       | 1              |               | 1                | 1 000,017       | 1                | _50.00  |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1312

|                  |       |   |                          |                  | T                         | o 12/31/2017             | Date/Time Pre 5/25/2018 5: 20 |                    |
|------------------|-------|---|--------------------------|------------------|---------------------------|--------------------------|-------------------------------|--------------------|
|                  |       |   |                          | CAP              | TAL RELATED CO            | OSTS                     | 372372010 3.2                 | J pili             |
|                  |       |   | _                        |                  |                           |                          |                               |                    |
|                  |       | Cost Center Description   | Net Expenses<br>for Cost | BLDG & FIXT      | BLDG & FIXT -<br>HOSPITAL | BLDG & FIXI -  <br>TLMOB | EMPLOYEE<br>BENEFITS          |                    |
|                  |       |   | Allocation               |                  | HUSPITAL                  | ILWOD                    | DEPARTMENT                    |                    |
|                  |       |   | (from Wkst A             |                  |                           |                          | DEI ARTIMENT                  |                    |
|                  |       |   | col . 7)                 |                  |                           |                          |                               |                    |
|                  |       |   | 0                        | 1. 00            | 1. 01                     | 1. 02                    | 4. 00                         |                    |
| 4 00             |       | AL SERVICE COST CENTERS   | 07.470                   | 07.470           | ı                         |                          |                               | 4 00               |
| 1. 00<br>1. 01   |       | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - HOSPITAL          | 97, 173<br>3, 003, 907   | 97, 173<br>0     |                           |                          |                               | 1. 00<br>1. 01     |
| 1.01             | 1     | CAP REL COSTS-BLDG & FIXT - HOSPITAL  CAP REL COSTS-BLDG & FIXT - TLMOB | 642, 755                 | 0                |                           |                          |                               | 1. 01              |
| 4. 00            |       | EMPLOYEE BENEFITS DEPARTMENT  | 1, 239, 547              | 0                |                           | 042, 733                 | 1, 239, 547                   | 4. 00              |
| 5. 00            | 1     | ADMINISTRATIVE & GENERAL  | 4, 680, 731              | 10, 847          | 91, 562                   | 157, 761                 | 104, 315                      | 5. 00              |
| 7.00             | 00700 | OPERATION OF PLANT  | 230, 561                 | 0                | 0                         | o                        | 33, 073                       | 7. 00              |
| 7. 01            |       | OPERATION OF PLANT - HOSPITAL   | 1, 579, 053              | 16, 988          | 843, 550                  | 0                        | 0                             | 7. 01              |
| 7. 02            |       | OPERATION OF PLANT - TLMOB  | 264, 338                 | 8, 210           |                           | 143, 864                 | 0                             | 7. 02              |
| 8.00             |       | LAUNDRY & LINEN SERVICE   | 65, 338                  | 331              |                           |                          | 0                             | 8. 00              |
| 9. 00<br>10. 00  |       | HOUSEKEEPI NG<br>DI ETARY   | 380, 967                 | 1, 328<br>2, 932 |                           | 1, 565<br>51, 369        | 49, 497                       | 9. 00<br>10. 00    |
| 11. 00           |       | CAFETERI A  | 392, 238<br>15, 980      | 795              |                           |                          | 70, 947<br>11, 847            | 11. 00             |
| 13. 00           |       | NURSI NG ADMI NI STRATI ON  | 837, 308                 | 620              |                           |                          | 124, 822                      | 13. 00             |
| 14. 00           | 1     | CENTRAL SERVICES & SUPPLY   | 506, 138                 | 2, 923           |                           |                          | 0                             | 14. 00             |
| 15.00            |       | PHARMACY  | 577, 824                 | 1, 248           |                           |                          | 62, 307                       | 15. 00             |
| 16.00            | 01600 | MEDICAL RECORDS & LIBRARY   | 0                        | 0                | 0                         | 0                        | 0                             | 16. 00             |
|                  |       | ENT ROUTINE SERVICE COST CENTERS  |                          |                  |                           |                          |                               |                    |
| 30.00            |       | ADULTS & PEDI ATRI CS   | 1, 387, 738              | 10, 671          |                           |                          | 202, 903                      | 30. 00             |
| 31. 00<br>43. 00 |       | INTENSIVE CARE UNIT<br>NURSERY  | 0                        | 0                |                           |                          | 0                             | 31. 00<br>43. 00   |
| 43.00            |       | LARY SERVICE COST CENTERS   | l o                      | 0                | 0                         | l U                      | 0                             | 43.00              |
| 50.00            |       | OPERATI NG ROOM   | 701, 331                 | 7, 862           | 390, 411                  | 0                        | 79, 475                       | 50. 00             |
| 52.00            | 05200 | DELIVERY ROOM & LABOR ROOM  | 0                        | 0                | 0                         | 0                        | 0                             | 52.00              |
| 54.00            |       | RADI OLOGY-DI AGNOSTI C   | 365, 946                 | 3, 628           |                           |                          | 48, 773                       | 54.00              |
| 55. 00           |       | RADI OLOGY-THERAPEUTI C   | 98, 949                  | 411              |                           |                          | 11, 484                       |                    |
| 56.00            | 1     | ULTRA SOUND   | 140, 176                 | 284              |                           |                          | 8, 690                        |                    |
| 57. 00<br>58. 00 |       | CT SCAN MAGNETIC RESONANCE IMAGING (MRI)                                | 309, 196<br>120, 279     | 387<br>546       |                           |                          | 46, 685<br>17, 993            | 57. 00<br>58. 00   |
| 60.00            |       | LABORATORY  | 1, 220, 379              | 2, 020           |                           |                          | 17, 773                       | 60.00              |
| 66. 00           | 1     | PHYSI CAL THERAPY   | 289, 962                 | 1, 761           |                           |                          | 44, 277                       | 66. 00             |
| 67.00            | 1     | OCCUPATIONAL THERAPY  | 115, 988                 | 140              |                           |                          | 17, 618                       |                    |
| 68. 00           |       | SPEECH PATHOLOGY  | 78, 198                  | 66               | 3, 269                    | 0                        | 11, 414                       | 68. 00             |
| 69. 00           |       | ELECTROCARDI OLOGY  | 172, 789                 | 408              | 20, 274                   | 0                        | 23, 610                       |                    |
| 71. 00           |       | MEDICAL SUPPLIES CHARGED TO PATIENTS                                    | 21, 124                  | 0                |                           | 0                        | 0                             | 71. 00             |
| 72. 00           |       | I MPL. DEV. CHARGED TO PATIENTS   | 5, 686                   | 0                | 1                         | 0                        | 0                             | 72.00              |
| 73. 00<br>73. 01 |       | DRUGS CHARGED TO PATIENTS ONCOLOGY DRUGS                                | 429, 459<br>1, 248, 597  | 0                |                           | 0                        | 0                             | 73. 00<br>73. 01   |
| 76. 00           |       | CARDI OPULMONARY  | 367, 391                 | 1, 131           | 1                         | ı                        | 55, 645                       |                    |
|                  |       | TIENT SERVICE COST CENTERS  | 991/911                  | .,               |                           | -1                       | 22,212                        |                    |
| 90.00            |       | CLINIC  | 155, 446                 | 1, 267           | 62, 922                   | 0                        | 18, 740                       | 90. 00             |
| 91. 00           |       | EMERGENCY   | 2, 148, 668              | 5, 110           | 253, 750                  | 0                        | 181, 694                      |                    |
| 92.00            | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)                                    |                          |                  |                           |                          | 0                             | 92.00              |
| 92.01            |       | OBSERVATION BEDS (DISTINCT PART) REIMBURSABLE COST CENTERS              | 0                        | 0                | 0                         | 0                        | 0                             | 92. 01             |
| 101.00           |       | HOME HEALTH AGENCY  | O                        | 0                | 0                         | O                        | 0                             | 101. 00            |
|                  |       | AL PURPOSE COST CENTERS   | -1                       | -                |                           | -,                       |                               |                    |
| 118.00           |       | SUBTOTALS (SUM OF LINES 1 through 117)                                  | 23, 891, 160             | 81, 914          | 3, 003, 907               | 375, 375                 | 1, 225, 809                   | 118. 00            |
| 400.00           |       | MBURSABLE COST CENTERS  | ام                       |                  | 1                         |                          |                               | 400 00             |
|                  |       | GIFT, FLOWER, COFFEE SHOP & CANTEEN<br>RESEARCH                         | 0                        | 0                | 0                         | 0                        |                               | 190. 00<br>191. 00 |
|                  |       | PHYSICIANS' PRIVATE OFFICES   | 90, 503                  | 3, 116           | _                         | 54, 596                  | 13, 738                       |                    |
|                  | 19200 |   | 70, 503<br>N             | 10, 075          |                           | 176, 547                 |                               | 192. 00<br>192. 02 |
|                  |       | ARNETT SURGERY OFFICE   |                          | 2, 068           |                           | 36, 237                  |                               | 192. 02            |
|                  |       | OCCUPATI ONAL MEDI CI NE  | ol                       | 0                |                           | 0                        |                               | 192. 04            |
| 193.00           | 19300 | NONPALD WORKERS   | o                        | 0                | 0                         | o                        |                               | 193. 00            |
| 200.00           |       | Cross Foot Adjustments  |                          |                  |                           |                          |                               | 200. 00            |
| 201.00           |       | Negative Cost Centers   | 00 001 /:-               | 0                | 0                         | 0                        |                               | 201. 00            |
| 202.00           | ון    | TOTAL (sum lines 118 through 201)                                       | 23, 981, 663             | 97, 173          | 3, 003, 907               | 642, 755                 | 1, 239, 547                   | 202.00             |

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: |
| 5/25/2018 5:20 pm |

|                  |  |                         |                    | ''               | 0 12/31/2017       | 5/25/2018 5: 20 |                  |
|------------------|--|-------------------------|--------------------|------------------|--------------------|-----------------|------------------|
|                  | Cost Center Description  | Subtotal                | ADMI NI STRATI VE  | OPERATION OF     | OPERATION OF       | OPERATION OF    |                  |
|                  |  |                         | & GENERAL          | PLANT            | PLANT -            | PLANT - TLMOB   |                  |
|                  |  |                         |                    | 7.00             | HOSPI TAL          | 7.00            |                  |
|                  | DENERAL DERIVINE COOT DENTERO                                  | 4A                      | 5. 00              | 7. 00            | 7. 01              | 7. 02           |                  |
| 1 00             | GENERAL SERVICE COST CENTERS                                   |                         |                    |                  |                    |                 | 1 00             |
| 1.00             | 00100 CAP REL COSTS-BLDG & FLXT                                |                         |                    |                  |                    |                 | 1.00             |
| 1.01             | 00101 CAP REL COSTS-BLDG & FLXT - HOSPITAL                     |                         |                    |                  |                    |                 | 1. 01            |
| 1. 02            | 00102 CAP REL COSTS-BLDG & FIXT - TLMOB                        |                         |                    |                  |                    |                 | 1. 02            |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT                             | E 04E 04/               | E 045 047          |                  |                    |                 | 4.00             |
| 5.00             | 00500 ADMI NI STRATI VE & GENERAL                              | 5, 045, 216             |                    |                  |                    |                 | 5. 00            |
| 7.00             | 00700 OPERATION OF PLANT                                       | 263, 634                |                    |                  |                    |                 | 7. 00            |
| 7. 01            | 00701 OPERATION OF PLANT - HOSPITAL                            | 2, 439, 591             |                    |                  |                    | 550 400         | 7. 01            |
| 7. 02            | 00702 OPERATION OF PLANT - TLMOB                               | 416, 412                |                    |                  |                    | 559, 109        | 7. 02            |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE                                  | 82, 090                 |                    | 1, 279           |                    |                 | 8. 00            |
| 9.00             | 00900 HOUSEKEEPI NG  | 494, 878                |                    |                  |                    |                 | 9. 00            |
| 10.00            | 01000 DI ETARY   | 517, 486                |                    |                  |                    |                 |                  |
| 11. 00           | 01100 CAFETERI A   | 42, 559                 |                    |                  |                    | 22, 843         | 11.00            |
| 13.00            | 01300 NURSI NG ADMI NI STRATI ON                               | 980, 914                |                    |                  |                    | 11, 275         | 1                |
| 14. 00           | 01400 CENTRAL SERVI CES & SUPPLY                               | 654, 205                |                    |                  |                    |                 | 14.00            |
| 15.00            | 01500 PHARMACY   | 703, 367                | 187, 397           | 4, 828           |                    |                 | 15.00            |
| 16. 00           | 01600 MEDI CAL RECORDS & LI BRARY                              | 0                       | 0                  | 0                | U                  | 0               | 16. 00           |
| 20.00            | I NPATI ENT ROUTI NE SERVI CE COST CENTERS                     | 2 121 227               | F / 7 000          | 41.070           | 000 212            |                 | 20.00            |
| 30.00            | 03000 ADULTS & PEDI ATRI CS                                    | 2, 131, 226             |                    |                  |                    |                 | 30.00            |
| 31. 00           | 03100 I NTENSI VE CARE UNI T                                   | 0                       | 0                  | 0                | 0                  |                 | 31.00            |
| 43. 00           | 04300 NURSERY  | 0                       | 0                  | 0                | 0                  | 0               | 43. 00           |
| EO 00            | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM            | 1, 179, 079             | 214 141            | 20 407           | 595, 445           | 0               | <br>  EO OO      |
| 50.00            | 1  |                         |                    | 30, 407          |                    |                 | 50.00            |
| 52.00            | 05200 DELIVERY ROOM & LABOR ROOM                               | 0                       | 1                  | 14 022           |                    | 0               | 52.00            |
| 54. 00<br>55. 00 | 05400 RADI OLOGY-DI AGNOSTI C<br>05500 RADI OLOGY-THERAPEUTI C | 598, 513                |                    | 14, 032          |                    | _               | 54. 00<br>55. 00 |
| 56. 00           | 03630 ULTRA SOUND  | 131, 273                |                    | 1, 591<br>1, 097 | 31, 158<br>21, 484 |                 | 56.00            |
| 57. 00           | 05700 CT SCAN  | 163, 236                |                    |                  |                    |                 | •                |
|                  |  | 375, 491                |                    |                  |                    |                 | 57.00            |
| 58. 00           | 05800 MAGNETIC RESONANCE IMAGING (MRI)                         | 165, 940                |                    | 2, 112           |                    |                 | 58. 00           |
| 60.00            | 06000 LABORATORY   | 1, 322, 716             |                    |                  |                    | 0               | 60.00            |
| 66. 00           | 06600 PHYSI CAL THERAPY<br>06700 OCCUPATI ONAL THERAPY         | 423, 437                |                    |                  |                    | 0               | 66.00            |
| 67. 00<br>68. 00 | 06800 SPEECH PATHOLOGY   | 140, 711<br>92, 947     | 37, 489<br>24, 764 |                  |                    |                 | 67. 00<br>68. 00 |
| 69. 00           | 06900 ELECTROCARDI OLOGY                                       | ·                       |                    | 1, 579           |                    | 0               | 69.00            |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                     | 217, 081                | 57, 837            |                  | 30, 921            |                 | 71.00            |
| 71.00            | 07200 IMPL. DEV. CHARGED TO PATIENTS                           | 21, 124                 |                    | 0                | 0                  | 0               | 71.00            |
| 72.00            | 07300 DRUGS CHARGED TO PATIENTS                                | 5, 686                  |                    | 0                | 0                  |                 | 72.00            |
| 73. 00           | 07300 DRUGS CHARGED TO PATTENTS                                | 429, 459<br>1, 248, 597 |                    |                  | 0                  |                 | 73.00            |
| 76. 00           | 03020 CARDI OPULMONARY   | 480, 318                |                    | 4, 373           | 85, 640            |                 | 76.00            |
| 76.00            | OUTPATIENT SERVICE COST CENTERS                                | 400, 310                | 127, 971           | 4, 3/3           | 65, 640            | 0               | 76.00            |
| 90. 00           | 09000 CLINIC   | 238, 375                | 63, 510            | 4, 901           | 95, 967            | 0               | 90.00            |
| 91. 00           | 09100 EMERGENCY  | 2, 589, 222             |                    | 19, 763          |                    | 0               | 91.00            |
| 92. 00           | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                     | 2, 307, 222             |                    | 17, 703          | 307,013            |                 | 92.00            |
| 92. 01           | 09201 OBSERVATION BEDS (NON BISTINGT PART)                     | 0                       |                    | 0                | 0                  | o               | 92. 01           |
| 72.01            | OTHER REIMBURSABLE COST CENTERS                                |                         |                    | ·                | <u> </u>           |                 | /2.01            |
| 101 00           | 10100 HOME HEALTH AGENCY                                       | 0                       | 0                  | 0                | 0                  | 0               | 101.00           |
| 101.00           | SPECIAL PURPOSE COST CENTERS                                   |                         |                    | <u> </u>         | J                  |                 | 101.00           |
| 118. 00          |  | 23, 594, 783            | 4, 942, 139        | 274, 860         | 3, 155, 271        | 120, 878        | 118 00           |
|                  | NONREI MBURSABLE COST CENTERS                                  | 20/07/1/700             | 177127107          | 27 17 000        | 0, 100, 2, 1       | 1207070         | 1                |
| 190.00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                      | 0                       | 0                  | 0                | 0                  | 0               | 190. 00          |
|                  | 19100 RESEARCH   | 0                       | 0                  | 0                | 0                  |                 | 191. 00          |
|                  | 19200 PHYSICIANS' PRIVATE OFFICES                              | 161, 953                | 43, 149            | 12, 050          | 0                  | 89, 483         |                  |
|                  | 19202 MOB  | 186, 622                |                    |                  |                    | 289, 355        |                  |
|                  | 19203 ARNETT SURGERY OFFICE                                    | 38, 305                 |                    |                  |                    | 59, 393         | •                |
|                  | 19201 OCCUPATIONAL MEDICINE                                    | 0                       | l, _00             | l .,,,,          | l o                |                 | 192. 04          |
|                  | 19300 NONPALD WORKERS  | 0                       | l 0                | l                | o o                |                 | 193. 00          |
| 200.00           |  | 0                       |                    |                  |                    |                 | 200. 00          |
| 201.00           | 1 1  | 0                       | 0                  | 0                | o                  |                 | 201. 00          |
| 202.00           |  | 23, 981, 663            | 5, 045, 216        | 333, 874         | 3, 155, 271        |                 |                  |
|                  | ,                        |                         |                    | •                |                    | •               |                  |

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: |
| 5/25/2018 5:20 pm |

|  |               |               |          | 12/31/2017 | 5/25/2018 5: 2    |         |
|--|---------------|---------------|----------|------------|-------------------|---------|
| Cost Center Description                              | LAUNDRY &     | HOUSEKEEPI NG | DI ETARY | CAFETERI A | NURSI NG          |         |
| P  | LINEN SERVICE |               |          |            | ADMI NI STRATI ON |         |
|  | 8.00          | 9. 00         | 10.00    | 11. 00     | 13. 00            |         |
| GENERAL SERVICE COST CENTERS                         |               |               |          |            |                   |         |
| 1.00 00100 CAP REL COSTS-BLDG & FLXT                 |               |               |          |            |                   | 1.00    |
| 1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL      |               |               |          |            |                   | 1. 01   |
| 1.02 O0102 CAP REL COSTS-BLDG & FIXT - TLMOB         |               |               |          |            |                   | 1. 02   |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT              |               |               |          |            |                   | 4.00    |
| 5. 00 00500 ADMINISTRATIVE & GENERAL                 |               |               |          |            |                   | 5. 00   |
| 7. 00 00700 OPERATION OF PLANT                       |               |               |          |            |                   | 7. 00   |
| 7. 01 00701 OPERATION OF PLANT - HOSPITAL            |               |               |          |            |                   | 7. 01   |
| 7. 02 00702 OPERATION OF PLANT - TLMOB               |               |               |          |            |                   | 7. 02   |
| 8. 00   00800 LAUNDRY & LINEN SERVICE                | 130, 285      |               |          |            |                   | 8. 00   |
| 9. 00   00900   HOUSEKEEPI NG                        | 130, 203      | 728, 261      |          |            |                   | •       |
|  | 0             |               | 770 755  |            |                   | 9.00    |
| 10. 00 01000 DI ETARY                                | 0             | 27, 864       | 778, 755 | 07.447     |                   | 10.00   |
| 11. 00   01100   CAFETERI A                          | 0             | 7, 599        | 0        | 87, 416    |                   | 11. 00  |
| 13.00 O1300 NURSING ADMINISTRATION                   | 0             | 0             | 0        | 9, 351     | 1, 282, 492       | 13. 00  |
| 14.00 O1400 CENTRAL SERVICES & SUPPLY                | 0             | 2, 850        | 0        | 0          | 0                 | 14. 00  |
| 15. 00   01500   PHARMACY                            | 0             | 26, 597       | 0        | 3, 417     | 0                 | 15. 00  |
| 16.00 01600 MEDICAL RECORDS & LIBRARY                | 0             | 0             | 0        | 0          | 0                 | 16. 00  |
| INPATIENT ROUTINE SERVICE COST CENTERS               |               |               |          |            |                   |         |
| 30. 00  03000  ADULTS & PEDI ATRI CS                 | 130, 285      | 163, 066      | 778, 755 | 19, 194    | 709, 347          | 30. 00  |
| 31.00   03100   INTENSIVE CARE UNIT                  | 0             | 0             | 0        | 0          | 0                 | 31.00   |
| 43. 00   04300 NURSERY                               | 0             | 0             | 0        | 0          | 0                 | 43.00   |
| ANCILLARY SERVICE COST CENTERS                       |               |               |          |            |                   |         |
| 50. 00 05000 OPERATING ROOM                          | 0             | 96, 574       | 0        | 6, 376     | 139, 043          | 50.00   |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM               | 0             | 0             | o        | 0          | 0                 | 52.00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                 | o             | 25, 964       | o        | 4, 594     | 0                 | 54.00   |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C                 | o             | 2, 850        | l o      | 777        | 0                 | 55.00   |
| 56. 00   03630   ULTRA SOUND                         | 0             | 1, 900        | 0        | 654        | 0                 | 56.00   |
| 57.00 05700 CT SCAN                                  | 0             | 2, 850        | 0        | 3, 858     | 0                 | 57. 00  |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)        | 0             | 3, 800        | 0        | 1, 569     | 0                 | 58. 00  |
| 60. 00   06000   LABORATORY                          |               | 38, 313       | 0        | 8, 477     | 0                 | 60.00   |
| 66. 00 06600 PHYSI CAL THERAPY                       |               | 28, 814       | 0        | 3, 384     | 0                 | 66.00   |
| 67. 00 06700 OCCUPATI ONAL THERAPY                   |               | 2, 216        | 0        | 866        | 0                 | 67. 00  |
| 68. 00 06800 SPEECH PATHOLOGY                        |               | 950           | 0        | 572        | 0                 | 68. 00  |
| 69. 00   06900   ELECTROCARDI OLOGY                  |               | 730           | 0        | 1, 300     | 0                 | 69.00   |
|  |               | 0             | 0        | 1, 300     | 0                 | •       |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0             | 0             | 0        | U          | -                 | 71.00   |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0             | U             | 0        | U          | 0                 | 72.00   |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS               | 0             | 0             | 0        | 0          | 0                 | 73. 00  |
| 73. 01   07301   0NCOLOGY DRUGS                      | 0             | 0             | 0        | 0          | 0                 | 73. 01  |
| 76. 00 03020 CARDI OPULMONARY                        | 0             | 27, 231       | 0        | 5, 281     | 0                 | 76. 00  |
| OUTPATIENT SERVICE COST CENTERS                      |               |               |          |            |                   |         |
| 90. 00  09000   CLI NI C                             | 0             | 13, 932       | 0        | 1, 708     | 0                 | 90. 00  |
| 91. 00   09100   EMERGENCY                           | 0             | 105, 756      | 0        | 14, 575    | 434, 102          | 91. 00  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)     |               |               |          |            |                   | 92. 00  |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART)         | 0             | 0             | 0        | 0          | 0                 | 92. 01  |
| OTHER REIMBURSABLE COST CENTERS                      |               |               |          |            |                   |         |
| 101.00 10100 HOME HEALTH AGENCY                      | 0             | 0             | 0        | 0          | 0                 | 101.00  |
| SPECIAL PURPOSE COST CENTERS                         | ·             |               | '        |            |                   |         |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)        | 130, 285      | 579, 126      | 778, 755 | 85, 953    | 1, 282, 492       | 118.00  |
| NONREI MBURSABLE COST CENTERS                        | ,             |               | ,        |            | .,,               |         |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN    |               | 0             | 0        | Ο          | 0                 | 190. 00 |
| 191. 00 19100 RESEARCH                               |               | 0             | Ö        | 0          |                   | 191. 00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES         |               | 32, 297       | 0        | 1, 463     |                   | 192. 00 |
| 192. 02 19202 MOB                                    | 1             |               | -        | 1, 403     |                   | 192. 00 |
|  | 0             | 116, 838      |          | U S        |                   |         |
| 192. 03 19203 ARNETT SURGERY OFFICE                  |               | 0             |          | 0          |                   | 192. 03 |
| 192. 04 19201 OCCUPATI ONAL MEDI CI NE               | 0             | 0             | 0        | 0          |                   | 192. 04 |
| 193. 00 19300 NONPALD WORKERS                        |               | O             | 0        | o          | 0                 | 193. 00 |
| 200.00 Cross Foot Adjustments                        |               |               |          |            |                   | 200. 00 |
| 201.00 Negative Cost Centers                         | 0             | 0             | 0        | 0          |                   | 201. 00 |
| 202.00   TOTAL (sum lines 118 through 201)           | 130, 285      | 728, 261      | 778, 755 | 87, 416    | 1, 282, 492       | 202. 00 |
|  |               |               |          |            |                   |         |

Health Financial Systems

IU HEALTH WHITE HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1312
Period: From 01/01/2017 To 12/31/2017
Part I Date/Time Prepared: 5/25/2018 5: 20 pm

|                    |   |                    |                      |           | To 12/31/2017               |                      |                    |
|--------------------|---|--------------------|----------------------|-----------|-----------------------------|----------------------|--------------------|
|                    | Cost Center Description   | CENTRAL            | PHARMACY             | MEDI CAL  | Subtotal                    | 5/25/2018 5: 2       | O pili             |
|                    |   | SERVICES &         |                      | RECORDS & |                             | Residents Cost       |                    |
|                    |   | SUPPLY             |                      | LI BRARY  |                             | & Post               |                    |
|                    |   |                    |                      |           |                             | Stepdown             |                    |
|                    |   | 14. 00             | 15. 00               | 16. 00    | 24.00                       | Adjustments<br>25.00 |                    |
|                    | GENERAL SERVICE COST CENTERS  | 14.00              | 15.00                | 10.00     | 24.00                       | 25.00                |                    |
| 1.00               | 00100 CAP REL COSTS-BLDG & FIXT   |                    |                      |           |                             |                      | 1.00               |
| 1. 01              | 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL                                  |                    |                      |           |                             |                      | 1. 01              |
| 1.02               | 00102 CAP REL COSTS-BLDG & FIXT - TLMOB                                     |                    |                      |           |                             |                      | 1. 02              |
| 4.00               | 00400 EMPLOYEE BENEFITS DEPARTMENT  |                    |                      |           |                             |                      | 4. 00              |
| 5.00               | 00500 ADMINISTRATIVE & GENERAL  |                    |                      |           |                             |                      | 5. 00              |
| 7.00               | 00700 OPERATION OF PLANT  |                    |                      |           |                             |                      | 7. 00              |
| 7. 01              | 00701 OPERATION OF PLANT - HOSPITAL   |                    |                      |           |                             |                      | 7. 01              |
| 7. 02<br>8. 00     | 00702 OPERATION OF PLANT - TLMOB<br>00800 LAUNDRY & LINEN SERVICE           |                    |                      |           |                             |                      | 7. 02<br>8. 00     |
| 9. 00              | 00900 HOUSEKEEPING  |                    |                      |           |                             |                      | 9. 00              |
| 10. 00             | 01000 DI ETARY  |                    |                      |           |                             |                      | 10.00              |
| 11. 00             | 01100 CAFETERI A  |                    |                      |           |                             |                      | 11. 00             |
| 13.00              | 01300 NURSING ADMINISTRATION  |                    |                      |           |                             |                      | 13.00              |
| 14.00              | 01400 CENTRAL SERVICES & SUPPLY   | 1, 064, 029        |                      |           |                             |                      | 14. 00             |
| 15. 00             | 01500 PHARMACY  | 31, 581            | 1, 051, 729          |           |                             |                      | 15. 00             |
| 16. 00             | 01600 MEDICAL RECORDS & LIBRARY   | 0                  | 0                    |           | 0                           |                      | 16. 00             |
| 20.00              | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS            | 141 17/            | 4 500                |           | 0 5 404 053                 |                      | 20.00              |
| 30. 00<br>31. 00   | 03100 INTENSIVE CARE UNIT   | 141, 176           | 4, 500<br>0          |           | 0 5, 494, 853<br>0 0        |                      | 30. 00<br>31. 00   |
| 43. 00             | 04300 NURSERY   |                    | o                    |           |                             |                      |                    |
| 10.00              | ANCILLARY SERVICE COST CENTERS  | <u> </u>           | <u>-</u>             |           | <u> </u>                    |                      | 10.00              |
| 50.00              | 05000 OPERATING ROOM  | 229, 280           | 1, 605               |           | 0 2, 591, 950               | 0                    | 50. 00             |
| 52.00              | 05200 DELIVERY ROOM & LABOR ROOM  | 0                  | 0                    |           | 0                           | 0                    | 52. 00             |
| 54. 00             | 05400 RADI OLOGY-DI AGNOSTI C   | 4, 339             | 1, 789               |           | 0 1, 083, 476               | l .                  | 54. 00             |
| 55. 00             | 05500 RADI OLOGY-THERAPEUTI C   | 1, 166             | 5                    |           | 0 203, 795                  |                      | 55.00              |
| 56.00              | 03630 ULTRA SOUND<br>05700 CT SCAN  | 6, 412             | 0                    |           | 0 238, 274                  | l .                  | 56. 00<br>57. 00   |
| 57. 00<br>58. 00   | 05800 MAGNETIC RESONANCE IMAGING (MRI)                                      | 98, 016<br>12, 561 | 23<br>0              |           | 0 611, 095<br>0 271, 559    | l .                  | 58.00              |
| 60.00              | 06000 LABORATORY  | 12, 301            | Ö                    |           | 0 1, 882, 730               | l .                  | 60.00              |
| 66. 00             | 06600 PHYSI CAL THERAPY   | 14, 692            | 9                    |           | 0 723, 318                  | l .                  | 66. 00             |
| 67.00              | 06700 OCCUPATI ONAL THERAPY   | 474                | 0                    |           | 0 192, 922                  | 0                    | 67. 00             |
| 68. 00             | 06800 SPEECH PATHOLOGY  | 0                  | 0                    |           | 0 124, 473                  | l .                  | 68. 00             |
| 69. 00             | 06900 ELECTROCARDI OLOGY  | 8, 459             | 43                   |           | 0 317, 220                  | l .                  | 69. 00             |
| 71. 00             | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                  | 134, 214           | 0                    |           | 0 160, 966                  | l .                  | 71.00              |
| 72. 00             | 07200 IMPL. DEV. CHARGED TO PATIENTS<br>07300 DRUGS CHARGED TO PATIENTS     | 10, 732            | 0                    |           | 0 17, 933                   |                      | 72.00              |
| 73. 00<br>73. 01   | 07300 DRUGS CHARGED TO PATTENTS   | 0                  | 265, 086<br>770, 702 |           | 0 808, 965<br>0 2, 351, 961 |                      | 73. 00<br>73. 01   |
| 76. 00             | 03020 CARDI OPULMONARY  | 33, 683            | 268                  |           | 0 764, 765                  |                      | 76. 00             |
|                    | OUTPATIENT SERVICE COST CENTERS   | 22,222             |                      |           |                             |                      |                    |
| 90.00              | 09000 CLI NI C  | 12, 482            | 707                  |           | 0 431, 582                  | 0                    | 90. 00             |
| 91. 00             | 09100 EMERGENCY   | 321, 891           | 6, 978               |           | 0 4, 569, 141               | l .                  | 91. 00             |
| 92. 00             | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                  |                    |                      |           |                             | 0                    | 92.00              |
| 92. 01             | O9201   OBSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS  | 0                  | 0                    |           | 0 0                         | 0                    | 92. 01             |
| 101.00             | 10100 HOME HEALTH AGENCY  | O                  | O                    |           | 0 0                         | 0                    | 101. 00            |
|                    | SPECIAL PURPOSE COST CENTERS  | - 1                | - '                  |           |                             |                      |                    |
| 118.00             |   | 1, 061, 158        | 1, 051, 715          |           | 0 22, 840, 978              | 0                    | 118. 00            |
| 100.00             | NONREIMBURSABLE COST CENTERS<br>  1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN | ٥                  | ol                   |           | 0 0                         |                      | 190. 00            |
|                    | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                   |                    | ol<br>Ol             |           | 0 0                         |                      | 190.00             |
|                    | 19200 PHYSICIANS' PRIVATE OFFICES   | 2, 871             | 14                   |           | 0 343, 280                  | l .                  | 192. 00            |
|                    | 19202 MOB   | o                  | o                    |           | 0 681, 503                  |                      | 192. 02            |
| 192. 03            | 19203 ARNETT SURGERY OFFICE   | o                  | О                    |           | 0 115, 902                  | 0                    | 192. 03            |
|                    | 19201 OCCUPATIONAL MEDICINE   | 0                  | 0                    |           | 0 0                         |                      | 192. 04            |
|                    | 19300 NONPAI D WORKERS  | 이                  | 0                    |           | 0                           |                      | 193. 00            |
| 200.00             |   |                    |                      |           | 0                           |                      | 200. 00<br>201. 00 |
| 201. 00<br>202. 00 |   | 1, 064, 029        | 1, 051, 729          |           | 0 23, 981, 663              |                      | 201.00             |
| 202.00             | 1. The (Sum Times Till till bugit 201)                                      | 1, 307, 527        | 1,001,127            | l         | 20, 701, 000                |                      | 1-02. 00           |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1312

|              |   |              | To 12/31/2017   Date/Time Pro<br>  5/25/2018 5:: |                  |
|--------------|---|--------------|--|------------------|
|              | Cost Center Description   | Total        | 372372010 3.                                     | 20 piii          |
|              | <u>'</u>  | 26.00        |  |                  |
|              | ERAL SERVICE COST CENTERS   |              |  |                  |
|              | 00 CAP REL COSTS-BLDG & FIXT                                      |              |  | 1. 00            |
|              | 01 CAP REL COSTS-BLDG & FIXT - HOSPITAL                           |              |  | 1. 01            |
|              | 02 CAP REL COSTS-BLDG & FIXT - TLMOB                              |              |  | 1. 02            |
|              | 00 EMPLOYEE BENEFITS DEPARTMENT                                   |              |  | 4. 00            |
|              | OOO ADMINISTRATIVE & GENERAL                                      |              |  | 5. 00            |
|              | OO OPERATION OF PLANT   |              |  | 7. 00            |
|              | 01 OPERATION OF PLANT - HOSPITAL                                  |              |  | 7. 01            |
|              | O2 OPERATION OF PLANT - TLMOB                                     |              |  | 7. 02            |
|              | 300 LAUNDRY & LINEN SERVICE                                       |              |  | 8. 00            |
|              | OOO HOUSEKEEPI NG   |              |  | 9.00             |
|              | OO DI ETARY   |              |  | 10.00            |
|              | OO CAFETERIA  |              |  | 11.00            |
|              | OO OF STRAIN SERVICES & SUPPLY                                    |              |  | 13.00            |
|              | OO CENTRAL SERVICES & SUPPLY                                      |              |  | 14.00            |
|              | OO PHARMACY   |              |  | 15. 00<br>16. 00 |
|              | 00 MEDICAL RECORDS & LIBRARY ATIENT ROUTINE SERVICE COST CENTERS  |              |  | 16.00            |
|              | 000 ADULTS & PEDIATRICS   | 5, 494, 853  |  | 30.00            |
|              | OO INTENSIVE CARE UNIT  | 0, 171, 000  |  | 31. 00           |
|              | NURSERY   | o            |  | 43. 00           |
|              | ILLARY SERVICE COST CENTERS                                       | 91           |  | 1 .0.00          |
|              | 000 OPERATING ROOM  | 2, 591, 950  |  | 50.00            |
| 52. 00 052   | OO DELIVERY ROOM & LABOR ROOM                                     | 0            |  | 52. 00           |
|              | 00 RADI OLOGY-DI AGNOSTI C  | 1, 083, 476  |  | 54.00            |
| 55. 00 055   | 00 RADI OLOGY-THERAPEUTI C  | 203, 795     |  | 55. 00           |
| 56. 00   036 | 30 ULTRA SOUND  | 238, 274     |  | 56. 00           |
| 57. 00 057   | OO CT SCAN  | 611, 095     |  | 57. 00           |
| 58. 00   058 | MAGNETIC RESONANCE IMAGING (MRI)                                  | 271, 559     |  | 58. 00           |
| 60.00 060    | 000 LABORATORY  | 1, 882, 730  |  | 60.00            |
| 66. 00 066   | 00 PHYSI CAL THERAPY  | 723, 318     |  | 66. 00           |
| 67. 00   067 | OO OCCUPATIONAL THERAPY   | 192, 922     |  | 67. 00           |
| 68. 00 068   | 300 SPEECH PATHOLOGY  | 124, 473     |  | 68. 00           |
| 69. 00 069   | 000 ELECTROCARDI OLOGY  | 317, 220     |  | 69. 00           |
|              | 00 MEDICAL SUPPLIES CHARGED TO PATIENTS                           | 160, 966     |  | 71. 00           |
|              | 200 IMPL. DEV. CHARGED TO PATIENTS                                | 17, 933      |  | 72. 00           |
|              | DRUGS CHARGED TO PATIENTS   | 808, 965     |  | 73. 00           |
|              | 01 ONCOLOGY DRUGS   | 2, 351, 961  |  | 73. 01           |
|              | 20 CARDI OPULMONARY   | 764, 765     |  | 76. 00           |
|              | PATIENT SERVICE COST CENTERS                                      | 404 500      |  |                  |
|              | 000 CLINIC  | 431, 582     |  | 90.00            |
|              | OO EMERGENCY  | 4, 569, 141  |  | 91.00            |
|              | OO OBSERVATION BEDS (NON-DISTINCT PART)                           |              |  | 92. 00<br>92. 01 |
|              | 201 OBSERVATION BEDS (DISTINCT PART) ER REIMBURSABLE COST CENTERS | 0            |  | 92.01            |
|              | OO HOME HEALTH AGENCY   | 0            |  | 101.00           |
|              | CIAL PURPOSE COST CENTERS   | <u> </u>     |  | 101.00           |
| 118. 00      | SUBTOTALS (SUM OF LINES 1 through 117)                            | 22, 840, 978 |  | 118. 00          |
|              | REIMBURSABLE COST CENTERS   | ,            |  |                  |
|              | 000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                           | 0            |  | 190. 00          |
| 191. 00 191  | 00 RESEARCH   | 0            |  | 191. 00          |
| 192. 00 192  | 200 PHYSICIANS' PRIVATE OFFICES                                   | 343, 280     |  | 192. 00          |
| 192. 02 192  |   | 681, 503     |  | 192. 02          |
| 192. 03 192  | 03 ARNETT SURGERY OFFICE  | 115, 902     |  | 192. 03          |
|              | 01 OCCUPATIONAL MEDICINE  | 0            |  | 192. 04          |
|              | NONPALD WORKERS   | 0            |  | 193. 00          |
| 200. 00      | Cross Foot Adjustments  | 0            |  | 200. 00          |
| 201.00       | Negative Cost Centers   | 0            |  | 201. 00          |
| 202.00       | TOTAL (sum lines 118 through 201)                                 | 23, 981, 663 |  | 202. 00          |
|              |   |              |  |                  |

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Part II | Prepared: | From 12/31/2017 | Prepa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1312

|                         |  |                         |                       | T             | o 12/31/2017 | Date/Time Pre<br>5/25/2018 5:2 |                    |
|-------------------------|--|-------------------------|-----------------------|---------------|--------------|--------------------------------|--------------------|
|                         |  |                         | CAPITAL RELATED COSTS |               |              | 37 237 2010 3. 2               | O piii             |
|                         |  |                         |                       |               |              |                                |                    |
| Cost Center Description |  | Directly                | BLDG & FIXT           | BLDG & FIXT - |              | Subtotal                       |                    |
|                         |  | Assigned New<br>Capital |                       | HOSPI TAL     | TLMOB        |                                |                    |
|                         |  | Related Costs           |                       |               |              |                                |                    |
|                         |  | 0                       | 1.00                  | 1. 01         | 1. 02        | 2A                             |                    |
|                         | GENERAL SERVICE COST CENTERS   |                         |                       |               |              |                                |                    |
| 1.00                    | 00100 CAP REL COSTS-BLDG & FIXT  |                         |                       |               |              |                                | 1.00               |
| 1.01                    | 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL                               |                         |                       |               |              |                                | 1. 01              |
| 1. 02<br>4. 00          | 00102 CAP REL COSTS-BLDG & FLXT - TLMOB                                  | 0                       | 0                     | 0             |              | 0                              | 1. 02              |
| 5. 00                   | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00500 ADMINISTRATIVE & GENERAL     | 105, 559                | 10, 847               | 91, 562       | 157, 761     | 365, 729                       | 4. 00<br>5. 00     |
| 7. 00                   | 00700 OPERATION OF PLANT   | 103, 337                | 10, 047               | 71, 302       | 137, 701     | 0 303, 727                     | 7. 00              |
| 7. 01                   | 00701 OPERATION OF PLANT - HOSPITAL                                      | o                       | 16, 988               | 843, 550      | 0            | 860, 538                       | 7. 01              |
| 7. 02                   | 00702 OPERATION OF PLANT - TLMOB   | 0                       | 8, 210                |               | 143, 864     | 152, 074                       | 7. 02              |
| 8.00                    | 00800 LAUNDRY & LINEN SERVICE  | 0                       | 331                   | 16, 421       | 0            | 16, 752                        | 8. 00              |
| 9.00                    | 00900 HOUSEKEEPI NG  | 0                       | 1, 328                | 61, 521       | 1, 565       | 64, 414                        | 9. 00              |
| 10. 00                  | 01000 DI ETARY   | 0                       | 2, 932                |               | 51, 369      | 54, 301                        | 10. 00             |
| 11.00                   | 01100 CAFETERIA  | 0                       | 795                   |               | 13, 937      | 14, 732                        | 1                  |
| 13.00                   | 01300 NURSI NG ADMI NI STRATI ON   | 0                       | 620                   |               | 6, 879       | 18, 784                        | 13.00              |
| 14. 00<br>15. 00        | 01400 CENTRAL SERVI CES & SUPPLY<br>01500 PHARMACY                       | 0                       | 2, 923<br>1, 248      |               | 0            | 148, 067<br>63, 236            | 14. 00<br>15. 00   |
| 16. 00                  | 01600 MEDICAL RECORDS & LIBRARY  | 0                       | 1, 240                |               | 0            | 03, 230                        | 16.00              |
| 10.00                   | I NPATI ENT ROUTI NE SERVI CE COST CENTERS                               | ٥                       |                       |               | <u> </u>     |                                | 10.00              |
| 30.00                   |  | 0                       | 10, 671               | 529, 914      | 0            | 540, 585                       | 30.00              |
| 31.00                   | 03100 INTENSIVE CARE UNIT  | 0                       | 0                     | 0             | 0            | 0                              | 31. 00             |
| 43.00                   | 04300 NURSERY  | 0                       | 0                     | 0             | 0            | 0                              | 43. 00             |
| F0 00                   | ANCILLARY SERVICE COST CENTERS   | ما                      | 7.040                 | 1 200 444     |              | 200 070                        | <br>  FO 00        |
| 50. 00<br>52. 00        | 05000 OPERATING ROOM<br>05200 DELIVERY ROOM & LABOR ROOM                 | 0                       | 7, 862<br>0           |               | 0            | 398, 273<br>0                  | 50. 00<br>52. 00   |
| 54.00                   | 05400 RADI OLOGY-DI AGNOSTI C  | 0                       | 3, 628                |               | 0            | 183, 794                       | •                  |
| 55. 00                  | 05500 RADI OLOGY-THERAPEUTI C  | 0                       | 411                   |               | 0            | 20, 840                        | 1                  |
| 56. 00                  | 03630 ULTRA SOUND  | Ö                       | 284                   |               | o            | 14, 370                        | 1                  |
| 57.00                   | 05700 CT SCAN  | 0                       | 387                   | 19, 223       | 0            | 19, 610                        | 57. 00             |
| 58. 00                  | 05800 MAGNETIC RESONANCE IMAGING (MRI)                                   | 0                       | 546                   |               | 0            | 27, 668                        | 1                  |
| 60. 00                  | 06000 LABORATORY   | 0                       | 2, 020                |               | 0            | 102, 337                       |                    |
| 66.00                   | 06600 PHYSI CAL THERAPY  | 0                       | 1, 761                |               | 0            | 89, 198                        | •                  |
| 67. 00<br>68. 00        | 06700 OCCUPATI ONAL THERAPY<br>06800 SPEECH PATHOLOGY                    | 0                       | 140                   |               | 0            | 7, 105                         | •                  |
| 69.00                   | 06900 ELECTROCARDI OLOGY   | 0                       | 66<br>408             |               | 0            | 3, 335<br>20, 682              | •                  |
| 71. 00                  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                               | 0                       | 0                     | ·             | 0            | 20, 002                        | 71.00              |
| 72. 00                  |  | o                       | 0                     | Ö             | 0            | 0                              | •                  |
| 73. 00                  | 07300 DRUGS CHARGED TO PATIENTS  | 0                       | 0                     | 0             | 0            | 0                              | 73. 00             |
| 73. 01                  | 07301 ONCOLOGY DRUGS   | 0                       | 0                     | 0             | 0            | 0                              | 73. 01             |
| 76. 00                  | 03020 CARDI OPULMONARY   | 0                       | 1, 131                | 56, 151       | 0            | 57, 282                        | 76. 00             |
| 00.00                   | OUTPATIENT SERVICE COST CENTERS  | ol                      | 1 2/7                 | (2.022        |              | (4.100                         | 00.00              |
| 90. 00<br>91. 00        | 1  | 0                       | 1, 267<br>5, 110      |               | 0            | 64, 189<br>258, 860            | 90. 00<br>91. 00   |
| 92.00                   | 1 1  | U                       | 5, 110                | 253, 750      | J            | 258, 800                       | 1                  |
|                         |  | o                       | 0                     | 0             | 0            | 0                              | 1                  |
|                         | OTHER REIMBURSABLE COST CENTERS  | - 1                     |                       |               | -            |                                |                    |
| 101.00                  | 10100 HOME HEALTH AGENCY   | 0                       | 0                     | 0             | 0            | 0                              | 101. 00            |
|                         | SPECIAL PURPOSE COST CENTERS   |                         |                       |               |              |                                |                    |
| 118.00                  |  | 105, 559                | 81, 914               | 3, 003, 907   | 375, 375     | 3, 566, 755                    | 118. 00<br>        |
| 100 00                  | NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | ol                      | 0                     | 0             | 0            | 0                              | 190. 00            |
|                         | 19100 RESEARCH   | 0                       | 0                     |               | 0            |                                | 191. 00            |
|                         | 19200 PHYSICIANS' PRIVATE OFFICES  | o                       | 3, 116                |               | 54, 596      |                                | 192. 00            |
|                         | 2 19202 MOB  | o                       | 10, 075               |               | 176, 547     | 186, 622                       | 1                  |
|                         | 3 19203 ARNETT SURGERY OFFICE  | О                       | 2, 068                | 0             | 36, 237      | 38, 305                        |                    |
|                         | 4 19201 OCCUPATI ONAL MEDI CI NE   | 0                       | 0                     | 0             | 0            |                                | 192. 04            |
|                         | 0 19300 NONPAI D WORKERS   | 0                       | 0                     | 0             | 0            |                                | 193. 00            |
| 200.00                  | 1  |                         | ^                     |               |              |                                | 200. 00<br>201. 00 |
| 201. 00<br>202. 00      |  | 105, 559                | 97, 173               | 3, 003, 907   | 642, 755     | 3, 849, 394                    |                    |
| 202.00                  | TOTAL (Sum Times 110 through 201)  | 103, 334                | 71, 173               | 3,003,907     | 042, 755     | 5, 047, 374                    | 1202.00            |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1312

Period: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/25/2018 5:20 pm Cost Center Description **EMPLOYEE** ADMINISTRATIVE OPERATION OF OPERATION OF OPERATION OF **BENEFITS** PLANT -& GENERAL **PLANT** PLANT - TLMOB DEPARTMENT HOSPI TAL 5.00 7.00 7. 02 4.00 7.01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 1.02 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 0 365, 729 5.00 5.00 7.00 00700 OPERATION OF PLANT 0000000000 5, 092 5, 092 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 47, 116 908, 656 1,002 7.01 7.02 00702 OPERATION OF PLANT - TLMOB 8, 042 484 160, 600 7.02 8.00 00800 LAUNDRY & LINEN SERVICE 1, 585 20 7, 213 Ω 8.00 00900 HOUSEKEEPI NG 9.00 9.558 78 737 27, 021 9.00 01000 DI ETARY 9, 994 10.00 173 24, 184 10.00 11.00 01100 CAFETERI A 822 47 0 6,562 11.00 13.00 01300 NURSING ADMINISTRATION 18, 944 37 4, 956 3, 239 13.00 01400 CENTRAL SERVICES & SUPPLY 63, 750 12, 635 14.00 0 14.00 172 15.00 01500 PHARMACY 13, 584 74 27, 226 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 232, 749 30.00 41, 160 629 0 31.00 03100 INTENSIVE CARE UNIT 0 C 0 31.00 04300 NURSERY 0 0 43.00 43.00 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 22, 772 464 171, 476 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 000000000000000 11, 559 214 79, 132 0 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 2 535 24 8.973 55 00 0 03630 ULTRA SOUND 56.00 3, 153 17 6, 187 0 56.00 57.00 05700 CT SCAN 7, 252 23 8, 443 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 3, 205 32 11, 913 0 58.00 06000 LABORATORY 44, 061 60.00 25, 546 119 0 60.00 66.00 06600 PHYSI CAL THERAPY 8, 178 104 38, 404 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 2, 718 8 3,059 0 67.00 68 00 06800 SPEECH PATHOLOGY 1 795 1 436 0 68 00 4 06900 ELECTROCARDI OLOGY 69.00 4, 192 24 8, 905 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 408 0 71.00 71.00 C 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 110 0 o 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 8, 294 0 0 73 00 0 73.01 07301 ONCOLOGY DRUGS 24, 114 0 0 0 73.01 03020 CARDI OPULMONARY 9, 276 0 76.00 76.00 67 24, 663 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 75 27.637 0 4.604 91.00 09100 EMERGENCY 0 50, 014 301 111, 452 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.01 92.01 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 358, 257 4, 192 908, 656 34, 722 118. 00 118.00 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 25, 703 192. 00 0 3.128 184 192. 02 19202 MOB 3.604 594 0 83, 115 192. 02 192.03 19203 ARNETT SURGERY OFFICE 740 122 0 17, 060 192. 03 0 0 192. 04 19201 OCCUPATIONAL MEDICINE 0 192. 04 C C 0 193. 00 19300 NONPALD WORKERS r 0 0 0 193 00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 160, 600 202. 00 202.00 TOTAL (sum lines 118 through 201) 365, 729 5.092 908, 656

Provider CCN: 15-1312

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/25/2018 5:20 pm

|         |  |               |               |          |            | 5/25/2018 5: 2    | 0 pm    |
|---------|--|---------------|---------------|----------|------------|-------------------|---------|
|         | Cost Center Description                    | LAUNDRY &     | HOUSEKEEPI NG | DI ETARY | CAFETERI A | NURSI NG          |         |
|         |  | LINEN SERVICE |               |          |            | ADMI NI STRATI ON |         |
|         |  | 8. 00         | 9. 00         | 10.00    | 11. 00     | 13. 00            |         |
|         | GENERAL SERVICE COST CENTERS               | ·             |               |          |            |                   | 1       |
| 1.00    | 00100 CAP REL COSTS-BLDG & FIXT            |               |               |          |            |                   | 1. 00   |
| 1. 01   | OO1O1 CAP REL COSTS-BLDG & FIXT - HOSPITAL |               |               |          |            |                   | 1. 01   |
| 1.02    | 00102 CAP REL COSTS-BLDG & FIXT - TLMOB    |               |               |          |            |                   | 1. 02   |
| 4.00    | 00400 EMPLOYEE BENEFITS DEPARTMENT         |               |               |          |            |                   | 4. 00   |
| 5.00    | 00500 ADMINISTRATIVE & GENERAL             |               |               |          |            |                   | 5. 00   |
| 7.00    | 00700 OPERATION OF PLANT                   |               |               |          |            |                   | 7.00    |
| 7.01    | 00701 OPERATION OF PLANT - HOSPITAL        |               |               |          |            |                   | 7. 01   |
| 7.02    | 00702 OPERATION OF PLANT - TLMOB           |               |               |          |            |                   | 7. 02   |
| 8.00    | 00800 LAUNDRY & LINEN SERVICE              | 25, 570       |               |          |            |                   | 8.00    |
| 9.00    | 00900 HOUSEKEEPI NG                        | 0             | 101, 808      |          |            |                   | 9.00    |
| 10.00   | 01000 DI ETARY                             | 0             | 3, 895        | 92, 547  |            |                   | 10.00   |
| 11. 00  | 01100 CAFETERI A                           | 0             | 1, 062        | 0        | 23, 225    |                   | 11.00   |
| 13. 00  | 01300 NURSI NG ADMI NI STRATI ON           | 0             | 0             | o o      | 2, 485     | 48, 445           | 1       |
| 14. 00  | 01400 CENTRAL SERVICES & SUPPLY            | l o           | 398           | o o      | 2, 100     | 0                 | 1       |
| 15. 00  | 01500 PHARMACY                             | 0             | 3, 718        | 0        | 908        | <b>l</b>          | 1       |
| 16. 00  | 01600 MEDICAL RECORDS & LIBRARY            | 0             | 3, 710        | 0        | 700        | 0                 | 1       |
| 10.00   | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 0             | <u> </u>      | 0        |            | 0                 | 10.00   |
| 30. 00  | 03000 ADULTS & PEDIATRICS                  | 25, 570       | 22, 796       | 92, 547  | 5, 099     | 26, 795           | 30.00   |
|         | 03100   NTENSI VE CARE UNI T               |               | 1             |          | 5, 099     |                   | 1       |
| 31.00   | 1 1  | 0             | 0             | 0        | 0          | 0                 | 1       |
| 43. 00  | 04300 NURSERY                              | 0             | 0             | 0        | 0          | 0                 | 43. 00  |
| F0 00   | ANCILLARY SERVICE COST CENTERS             |               | 40 504        |          | 4 (04      | 5 050             |         |
| 50.00   | 05000 OPERATING ROOM                       | 0             | 13, 501       | 0        | 1, 694     | 5, 252            | 1       |
| 52. 00  | 05200 DELIVERY ROOM & LABOR ROOM           | 0             | 0             | 0        | 0          | 0                 |         |
| 54. 00  | 05400 RADI OLOGY-DI AGNOSTI C              | 0             | 3, 630        | 0        | 1, 221     | 0                 |         |
| 55. 00  | 05500 RADI OLOGY-THERAPEUTI C              | 0             | 398           | 0        | 206        | 0                 |         |
| 56. 00  | 03630 ULTRA SOUND                          | 0             | 266           | 0        | 174        | 0                 |         |
| 57. 00  | 05700  CT SCAN                             | 0             | 398           | 0        | 1, 025     | 0                 | 1       |
| 58. 00  | 05800   MAGNETIC RESONANCE I MAGING (MRI)  | 0             | 531           | 0        | 417        | 0                 |         |
| 60.00   | 06000 LABORATORY                           | 0             | 5, 356        | 0        | 2, 252     | 0                 | 60.00   |
| 66. 00  | 06600 PHYSI CAL THERAPY                    | 0             | 4, 028        | 0        | 899        | 0                 | 66. 00  |
| 67.00   | 06700 OCCUPATI ONAL THERAPY                | 0             | 310           | 0        | 230        | 0                 | 67. 00  |
| 68.00   | 06800 SPEECH PATHOLOGY                     | 0             | 133           | 0        | 152        | 0                 | 68. 00  |
| 69.00   | 06900 ELECTROCARDI OLOGY                   | 0             | 0             | 0        | 345        | 0                 | 69. 00  |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0             | 0             | 0        | 0          | 0                 | 71.00   |
| 72.00   | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0             | o             | 0        | 0          | 0                 | 72. 00  |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS            | 0             | o             | 0        | 0          | 0                 | 73.00   |
| 73. 01  | 07301 ONCOLOGY DRUGS                       | 0             | o             | o        | 0          | 0                 | 73. 01  |
| 76. 00  | 03020 CARDI OPULMONARY                     | 0             | 3, 807        | o        | 1, 403     | 0                 | 1       |
|         | OUTPATIENT SERVICE COST CENTERS            |               |               |          |            |                   | 1       |
| 90.00   | 09000 CLI NI C                             | 0             | 1, 948        | 0        | 454        | 0                 | 90.00   |
| 91. 00  | 09100 EMERGENCY                            | 0             | 14, 784       | 0        | 3, 872     | 16, 398           | 1       |
| 92. 00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | _             | ,             |          | -,         |                   | 92.00   |
| 92. 01  | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0             | 0             | 0        | 0          | 0                 | 1       |
| 72.01   | OTHER REIMBURSABLE COST CENTERS            |               | <u> </u>      | <u> </u> |            | <u> </u>          | 72.01   |
| 101 00  | 10100 HOME HEALTH AGENCY                   | 0             | 0             | 0        | 0          | 0                 | 101.00  |
| 101.00  | SPECIAL PURPOSE COST CENTERS               |               | <u> </u>      | 0        |            |                   | 101.00  |
| 118. 00 |  | 25, 570       | 80, 959       | 92, 547  | 22, 836    | 19 115            | 118. 00 |
| 110.00  | NONREI MBURSABLE COST CENTERS              | 23,370        | 00, 737       | 72, 347  | 22, 030    | 40, 443           | 1110.00 |
| 100 00  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  |               |               |          | 0          |                   | 190. 00 |
|         | 19000 GIFT, PLOWER, COFFEE SHOP & CANTEEN  | 0             | 0             | 0        | 0          |                   | 190.00  |
|         | 19100 RESEARCH                             | 0             | 1             | 0        |            |                   |         |
|         | 1 1  | 0             | 4, 515        | 0        | 389        |                   | 192.00  |
|         | 19202 MOB                                  | 0             | 16, 334       | 0        | 0          |                   | 192. 02 |
|         | 19203 ARNETT SURGERY OFFICE                | 0             | 0             | 0        | 0          |                   | 192. 03 |
|         | 19201 OCCUPATI ONAL MEDI CI NE             | 0             | 0             | 0        | 0          |                   | 192. 04 |
|         | 19300 NONPALD WORKERS                      | 0             | 이             | 0        | 0          | 0                 | 193. 00 |
| 200.00  |  |               |               |          |            |                   | 200. 00 |
| 201.00  |  | 0             | 0             | 0        | 0          |                   | 201. 00 |
| 202.00  | TOTAL (sum lines 118 through 201)          | 25, 570       | 101, 808      | 92, 547  | 23, 225    | 48, 445           | 202. 00 |
|         |  |               |               |          |            |                   |         |

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH WHITE HOSPITAL Provider CCN: 15-1312

|                    |       |   |                   |          |           | То             | 12/31/2017         | Date/Time Prep<br>5/25/2018 5:20 |                    |
|--------------------|-------|---|-------------------|----------|-----------|----------------|--------------------|----------------------------------|--------------------|
|                    |       | Cost Center Description   | CENTRAL           | PHARMACY | MEDI CAL  |                | Subtotal           | Intern &                         | J pili             |
|                    |       | ·   | SERVICES &        |          | RECORDS & |                |                    | Residents Cost                   |                    |
|                    |       |   | SUPPLY            |          | LI BRARY  |                |                    | & Post                           |                    |
|                    |       |   |                   |          |           |                |                    | Stepdown<br>Adjustments          |                    |
|                    |       |   | 14.00             | 15. 00   | 16. 00    |                | 24. 00             | 25. 00                           |                    |
|                    |       | AL SERVICE COST CENTERS   |                   |          |           |                |                    |                                  |                    |
| 1.00               |       | CAP REL COSTS-BLDG & FIXT   |                   |          |           |                |                    |                                  | 1. 00              |
| 1.01               |       | CAP REL COSTS-BLDG & FIXT - HOSPITAL                                |                   |          |           |                |                    |                                  | 1. 01              |
| 1. 02<br>4. 00     | 1     | CAP REL COSTS-BLDG & FIXT - TLMOB EMPLOYEE BENEFITS DEPARTMENT      |                   |          |           |                |                    |                                  | 1. 02<br>4. 00     |
| 5. 00              |       | ADMINISTRATIVE & GENERAL  |                   |          |           |                |                    |                                  | 5. 00              |
| 7. 00              | 1     | OPERATION OF PLANT  |                   |          |           |                |                    |                                  | 7. 00              |
| 7. 01              | 00701 | OPERATION OF PLANT - HOSPITAL                                       |                   |          |           |                |                    |                                  | 7. 01              |
| 7.02               | 00702 | OPERATION OF PLANT - TLMOB  |                   |          |           |                |                    |                                  | 7. 02              |
| 8.00               |       | LAUNDRY & LINEN SERVICE   |                   |          |           |                |                    |                                  | 8. 00              |
| 9.00               |       | HOUSEKEEPI NG   |                   |          |           |                |                    |                                  | 9.00               |
| 10. 00<br>11. 00   |       | DI ETARY<br>CAFETERI A  |                   |          |           |                |                    |                                  | 10. 00<br>11. 00   |
| 13. 00             |       | NURSING ADMINISTRATION  |                   |          |           |                |                    |                                  | 13. 00             |
| 14. 00             | 1     | CENTRAL SERVICES & SUPPLY   | 225, 022          |          |           |                |                    |                                  | 14. 00             |
| 15.00              | 1     | PHARMACY  | 6, 679            | 115, 425 |           |                |                    |                                  | 15. 00             |
| 16.00              |       | MEDICAL RECORDS & LIBRARY   | 0                 | 0        |           | 0              |                    |                                  | 16.00              |
|                    |       | I ENT ROUTINE SERVICE COST CENTERS                                  | 00.05/            | ابور     |           |                |                    |                                  |                    |
| 30.00              |       | ADULTS & PEDIATRICS   | 29, 856           | 494      |           | 0              | 1, 018, 280        | 0                                | 30.00              |
| 31. 00<br>43. 00   |       | INTENSIVE CARE UNIT<br>NURSERY                                      | 0                 | 0        |           | 0              | 0                  | 0                                | 31. 00<br>43. 00   |
| 43.00              |       | LARY SERVICE COST CENTERS   | ١                 | <u> </u> |           | O <sub>I</sub> | 0                  | U                                | 43.00              |
| 50.00              |       | OPERATING ROOM  | 48, 488           | 176      |           | 0              | 662, 096           | 0                                | 50.00              |
| 52.00              |       | DELIVERY ROOM & LABOR ROOM  | O                 | o        |           | 0              | 0                  | 0                                | 52.00              |
| 54.00              |       | RADI OLOGY-DI AGNOSTI C   | 918               | 196      |           | 0              | 280, 664           | 0                                | 54.00              |
| 55. 00             |       | RADI OLOGY-THERAPEUTI C   | 247               | 1        |           | 0              | 33, 224            | 0                                | 55. 00             |
| 56. 00<br>57. 00   |       | ULTRA SOUND<br>CT SCAN  | 1, 356<br>20, 729 | 0        |           | 0              | 25, 523<br>57, 483 | 0                                | 56. 00<br>57. 00   |
| 58. 00             |       | MAGNETIC RESONANCE IMAGING (MRI)                                    | 2, 656            | 0        |           | 0              | 46, 422            | 0                                | 58. 00             |
| 60.00              | 1     | LABORATORY  | 2,030             | ő        |           | 0              | 179, 671           | Ö                                | 60.00              |
| 66.00              | 1     | PHYSI CAL THERAPY   | 3, 107            | 1        |           | 0              | 143, 919           | 0                                | 66. 00             |
| 67. 00             |       | OCCUPATI ONAL THERAPY   | 100               | 0        |           | 0              | 13, 530            | 0                                | 67. 00             |
| 68. 00             | 1     | SPEECH PATHOLOGY  | 0                 | 0        |           | 0              | 6, 855             | 0                                | 68. 00             |
| 69. 00             | 1     | ELECTROCARDI OLOGY  | 1, 789            | 5        |           | 0              | 35, 942            | 0                                | 69. 00             |
| 71. 00<br>72. 00   |       | MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS | 28, 384<br>2, 270 | 0        |           | 0              | 28, 792<br>2, 380  | 0                                | 71. 00<br>72. 00   |
| 73. 00             |       | DRUGS CHARGED TO PATIENTS   | 2,270             | 29, 092  |           | 0              | 37, 386            | 0                                | 73. 00             |
| 73. 01             |       | ONCOLOGY DRUGS  | o                 | 84, 583  |           | 0              | 108, 697           | 0                                | 73. 01             |
| 76.00              | 03020 | CARDI OPULMONARY  | 7, 123            | 29       |           | 0              | 103, 650           | 0                                | 76.00              |
|                    |       | TIENT SERVICE COST CENTERS  |                   | .1       |           |                |                    |                                  |                    |
| 90.00              | 1     | CLINIC  | 2, 640            | 78       |           | 0              | 101, 625           | 0                                | 90.00              |
| 91. 00<br>92. 00   | 1     | EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)                      | 68, 073           | 766      |           | 0              | 524, 520           | 0                                | 91. 00<br>92. 00   |
| 92. 00             | 1     | OBSERVATION BEDS (NON-DISTINCT PART)                                | 0                 | 0        |           | 0              | 0                  | 0                                | 92. 00             |
| 72.01              |       | REIMBURSABLE COST CENTERS   | <u> </u>          | <u>~</u> |           | <u> </u>       |                    |                                  | 72.01              |
| 101.00             |       | HOME HEALTH AGENCY  | 0                 | 0        |           | 0              | 0                  | 0                                | 101. 00            |
|                    |       | AL PURPOSE COST CENTERS   |                   |          |           |                |                    |                                  |                    |
| 118.00             |       | SUBTOTALS (SUM OF LINES 1 through 117)                              | 224, 415          | 115, 424 |           | 0              | 3, 410, 659        | 0                                | 118. 00            |
| 100 00             |       | IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN         | O                 | ٥        |           |                | 0                  | 0                                | 190. 00            |
|                    |       | RESEARCH  | 0                 | 0        |           | 0              | 0                  |                                  | 190.00             |
|                    |       | PHYSICIANS' PRIVATE OFFICES   | 607               | 1        |           | 0              | 92, 239            |                                  | 192. 00            |
|                    | 19202 |   |                   | o        |           | 0              | 290, 269           |                                  | 192. 02            |
|                    |       | ARNETT SURGERY OFFICE   | 0                 | o        |           | 0              | 56, 227            |                                  | 192. 03            |
|                    |       | OCCUPATIONAL MEDICINE   | 0                 | 0        |           | 0              | 0                  |                                  | 192. 04            |
|                    |       | NONPALD WORKERS   | 0                 | O        |           | O              | 0                  |                                  | 193. 00            |
| 200. 00<br>201. 00 | 1     | Cross Foot Adjustments Negative Cost Centers                        |                   | 0        |           | 0              | 0                  |                                  | 200. 00<br>201. 00 |
| 201.00             | 1     | TOTAL (sum lines 118 through 201)                                   | 225, 022          | 115, 425 |           | 0              | 3, 849, 394        |                                  | 201.00             |
| 50                 | 1     |   |                   |          |           | - 1            | ., , . , . ,       | ,                                |                    |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Prepa Provider CCN: 15-1312

| Cost Center Description Total 26.00                        | 018 5: 20 pm |
|--|--------------|
|  |              |
|  |              |
| GENERAL SERVICE COST CENTERS                               |              |
| 1.00 O0100 CAP REL COSTS-BLDG & FIXT                       | 1.00         |
| 1.01   OO101 CAP REL COSTS-BLDG & FIXT - HOSPITAL          | 1. 01        |
| 1.02   00102   CAP REL COSTS-BLDG & FIXT - TLMOB           | 1. 02        |
| 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT                    | 4. 00        |
| 5.00 O0500 ADMINISTRATIVE & GENERAL                        | 5. 00        |
| 7.00   00700   OPERATI ON OF PLANT                         | 7. 00        |
| 7.01   OO701   OPERATI ON OF PLANT - HOSPI TAL             | 7. 01        |
| 7. 02   00702   OPERATI ON OF PLANT - TLMOB                | 7. 02        |
| 8.00   OO800   LAUNDRY & LINEN SERVICE                     | 8. 00        |
| 9. 00   00900   HOUSEKEEPI NG                              | 9. 00        |
| 10. 00   01000   DI ETARY                                  | 10. 00       |
| 11. 00  01100  CAFETERI A                                  | 11. 00       |
| 13.00   01300   NURSI NG ADMINI STRATI ON                  | 13. 00       |
| 14.00 O1400 CENTRAL SERVICES & SUPPLY                      | 14. 00       |
| 15. 00   01500   PHARMACY                                  | 15. 00       |
| 16. 00   01600   MEDI CAL RECORDS & LI BRARY               | 16. 00       |
| INPATIENT ROUTINE SERVICE COST CENTERS                     |              |
| 30. 00   03000  ADULTS & PEDI ATRI CS   1, 018, 280        | 30.00        |
| 31.00   03100   I NTENSI VE CARE UNIT   0                  | 31.00        |
| 43. 00   04300  NURSERY   0                                | 43. 00       |
| ANCI LLARY SERVI CE COST CENTERS                           |              |
| 50. 00   05000   OPERATI NG ROOM   662, 096                | 50.00        |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM   0             | 52. 00       |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C 280, 664          | 54. 00       |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C 33, 224           | 55. 00       |
| 56. 00   03630   ULTRA SOUND   25, 523                     | 56. 00       |
| 57. 00   05700   CT SCAN   57, 483                         | 57. 00       |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) 46, 422  | 58. 00       |
| 60. 00   06000   LABORATORY 179, 671                       | 60. 00       |
| 66. 00   06600   PHYSI CAL THERAPY 143, 919                | 66. 00       |
| 67. 00   06700   OCCUPATI ONAL THERAPY 13, 530             | 67. 00       |
| 68. 00   06800   SPEECH PATHOLOGY 6, 855                   | 68. 00       |
| 69. 00   06900   ELECTROCARDI OLOGY 35, 942                | 69. 00       |
| 71.00 OT100 MEDICAL SUPPLIES CHARGED TO PATIENTS 28, 792   | 71. 00       |
| 72.00 07200 MPL. DEV. CHARGED TO PATIENTS 2,380            | 72. 00       |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS 37, 386         | 73. 00       |
| 73. 01   07301   0NCOLOGY DRUGS   108, 697                 | 73. 01       |
| 76. 00 03020 CARDI OPULMONARY 103, 650                     | 76. 00       |
| OUTPATIENT SERVICE COST CENTERS                            |              |
| 90. 00   09000   CLI NI C   101, 625                       | 90.00        |
| 91. 00   09100   EMERGENCY 524, 520                        | 91.00        |
| 92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   | 92.00        |
| 92. 01   | 92. 01       |
| OTHER REI MBURSABLE COST CENTERS                           | 101.00       |
| 101. 00 10100 HOME HEALTH AGENCY 0                         | 101. 00      |
| SPECIAL PURPOSE COST CENTERS                               | 110.00       |
| 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 410, 659 | 118. 00      |
| NONREI MBURSABLE COST CENTERS                              | 100.00       |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0        | 190.00       |
| 191. 00 19100 RESEARCH 0                                   | 191. 00      |
| 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 92, 239      | 192. 00      |
| 192. 02   19202   MOB 290, 269                             | 192. 02      |
| 192. 03 19203 ARNETT SURGERY OFFI CE 56, 227               | 192. 03      |
| 192. 04 19201 OCCUPATI ONAL MEDI CI NE 0                   | 192. 04      |
| 193. 00 19300 NONPAI D WORKERS 0                           | 193. 00      |
| 200.00 Cross Foot Adjustments 0                            | 200.00       |
| 201.00 Negative Cost Centers 0                             | 201. 00      |
| 202.00   TOTAL (sum lines 118 through 201)   3,849,394     | 202. 00      |

Health Financial Systems IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1312 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/25/2018 5: 20 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT BLDG & FIXT -BLDG & FIXT -**EMPLOYEE** Reconciliation (SQUARE FEET) HOSPI TAL TLMOB **BENEFITS** (SQUARE FEET) (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1.00 1. 01 1. 02 5A 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 124,005 1 00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 77, 196 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 0 46, 809 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 7, 592, 537 4 00 4 00 0 C00500 ADMINISTRATIVE & GENERAL 5.00 13,842 2, 353 11, 489 638, 951 -5, 045, 216 5.00 7.00 00700 OPERATION OF PLANT 202, 581 0 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 21,678 0 7.01 21.678 C 00702 OPERATION OF PLANT - TLMOB 7 02 10, 477 7 02 10, 477 0 0 8.00 00800 LAUNDRY & LINEN SERVICE 422 422 0 8.00 00900 HOUSEKEEPI NG 303, 179 9.00 9.00 1,695 1,581 114 01000 DI ETARY 3,741 3, 741 434, 566 10.00 10.00 0 01100 CAFETERI A 1, 015 72, 568 11.00 1,015 0 11.00 13.00 01300 NURSING ADMINISTRATION 791 290 501 764, 567 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 3,730 3,730 14.00 01500 PHARMACY 1, 593 1, 593 0 381, 643 0 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 618 13, 618 0 1, 242, 854 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 04300 NURSERY 0 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 033 10, 033 0 50.00 486, 802 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 4,630 4,630 0 298, 744 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 525 525 70, 344 55.00 56.00 03630 ULTRA SOUND 362 0 53, 226 0 56.00 362 05700 CT SCAN 0 57.00 494 494 285, 954 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 697 58.00 697 110, 213 0 58.00 60.00 06000 LABORATORY 2,578 2, 578 0 0 60.00 06600 PHYSI CAL THERAPY 0 271, 209 66,00 2.247 2, 247 Λ 66,00 06700 OCCUPATI ONAL THERAPY 67.00 179 179 107, 912 0 67.00 06800 SPEECH PATHOLOGY 69, 916 68.00 84 84 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 144.617 521 521 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 07301 ONCOLOGY DRUGS 0 73 01 0 73 01 03020 CARDI OPULMONARY 76.00 1, 443 1, 443 0 340, 837 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 617 0 114, 786 0 90.00 1,617 09100 EMERGENCY 91 00 0 91 00 1, 112, 920 0 6.521 6, 521 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 0 0 OTHER REIMBURSABLE COST CENTERS 0 101. 00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) -5, 045, 216 118. 00 104, 533 77, 196 27, 337 7, 508, 389 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN വ വ 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 3,976 3, 976 84, 148 192. 02 19202 MOB 0 192, 02 12.857 12, 857 Ω 0 192.03 19203 ARNETT SURGERY OFFICE 2,639 2,639 0 0 192. 03 192. 04 19201 OCCUPATIONAL MEDICINE 0 0 192. 04 0 193. 00 19300 NONPALD WORKERS 0 193. 00 0 0 0 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 97, 173 3,003,907 642, 755 1, 239, 547 202.00 Part I) 203.00 203. 00 Unit cost multiplier (Wkst. B, Part I) 0.783622 38 912729 13 731441 0 163259 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 II)206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00

Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1312

Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Ti me Prepared:

5/25/2018 5:20 pm Cost Center Description ADMINISTRATIVE OPERATION OF OPERATION OF OPERATION OF LAUNDRY & PLANT - TLMOB LINEN SERVICE & GENERAL PLANT PLANT (ACCUM. COST) (SQUARE FEET) HOSPI TAL (SQUARE FEET) (PATIENT DAYS) (SQUARE FEET) 5.00 8. 00 7. 02 7.00 7.01 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 1.01 1.01 1.02 1 02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 18, 936, 447 5.00 00700 OPERATION OF PLANT 7.00 263, 634 110, 163 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 2, 439, 591 21,678 53, 165 7.01 7.0200702 OPERATION OF PLANT - TLMOB 416, 412 10, 477 24, 843 7.02 00800 LAUNDRY & LINEN SERVICE 82,090 422 422 2,090 8.00 8.00 00900 HOUSEKEEPI NG 1, 695 9 00 494, 878 1,581 9 00 114 Λ 10.00 01000 DI ETARY 517, 486 3, 741 C 3, 741 0 10.00 11.00 01100 CAFETERI A 42, 559 1, 015 1,015 0 11.00 01300 NURSING ADMINISTRATION 980, 914 791 290 501 13.00 0 13.00 01400 CENTRAL SERVICES & SUPPLY 3,730 14.00 654, 205 3,730 0 0 14.00 15.00 01500 PHARMACY 703, 367 1, 593 1,593 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 2, 131, 226 13, 618 13, 618 0 2, 090 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 43.00 04300 NURSERY 0 0 43.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 179, 079 10,033 10,033 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 598.513 4 630 4 630 54 00 0 05500 RADI OLOGY-THERAPEUTI C 55.00 131, 273 525 525 0 55.00 56.00 03630 ULTRA SOUND 163, 236 0 56.00 362 362 57.00 05700 CT SCAN 375, 491 494 494 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 165, 940 58 00 697 697 0 58 00 60.00 06000 LABORATORY 1, 322, 716 2,578 2,578 0 60.00 06600 PHYSI CAL THERAPY 423, 437 66.00 2.247 2.247 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 140, 711 179 179 0 67.00 06800 SPEECH PATHOLOGY 92, 947 84 0 68.00 68.00 84 69.00 06900 ELECTROCARDI OLOGY 217, 081 521 521 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 21, 124 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5.686 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 429, 459 73.00 C 0 0 73.00 73. 01 07301 ONCOLOGY DRUGS 1, 248, 597 0 0 73.01 76.00 03020 CARDI OPULMONARY 480, 318 1, 443 1, 443 0 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 90.00 09000 CLI NI C 238 375 1, 617 1, 617 0 0 91.00 09100 EMERGENCY 2, 589, 222 6, 521 6, 521 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.01 92.01 0 C 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 090 118. 00 18, 549, 567 5, 371 118.00 90, 691 53, 165 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 191, 00 0 C 0 0 3, 976 3, 976 192.00 19200 PHYSICIANS' PRIVATE OFFICES 161, 953 0 0 192.00 192. 02 19202 MOB 186, 622 12, 857 0 12, 857 0 192. 02 192. 03 19203 ARNETT SURGERY OFFICE 38, 305 0 0 192. 03 2.639 2.639 192. 04 19201 OCCUPATIONAL MEDICINE 0 0 192. 04 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 130, 285 202. 00 202.00 Cost to be allocated (per Wkst. B, 5, 045, 216 333, 874 3, 155, 271 559, 109 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 266429 3.030727 59. 348650 22. 505696 62. 337321 203. 00 204.00 Cost to be allocated (per Wkst. B, 365, 729 5, 092 908.656 160, 600 25, 570 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.019313 0.046222 17.091244 6.464598 12. 234450 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

|  | nancial Systems<br>CATION - STATISTICAL BASIS  | IU HEALTH WHI                           | TE HOSPITAL Provider CCN    | I: 15-1312 P                                 | In Lie   | u of Form CMS-2<br>Worksheet B-1                  |  |
|--|--|---|-----------------------------|--|--|---|--|
|  |  |   |                             | FI<br>To                                     | rom 01/01/2017<br>o 12/31/2017                               | Date/Time Pre<br>5/25/2018 5:2                    |  |
|  | Cost Center Description  | HOUSEKEEPING<br>(TIME SPENT)            | DI ETARY<br>(PATI ENT DAYS) |  | NURSI NG<br>ADMI NI STRATI ON<br>(DI RECT<br>NURSI NG HOURS) | CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)       | О рііі   |
|  |  | 9. 00                                   | 10.00                       | 11. 00                                       | 13. 00   | 14. 00  |  |
| 1. 00  | JERAL SERVICE COST CENTERS  100 CAP REL COSTS-BLDG & FIXT - HOSPITAL  101 CAP REL COSTS-BLDG & FIXT - TLMOB  102 CAP REL COSTS-BLDG & FIXT - TLMOB  100 EMPLOYEE BENEFITS DEPARTMENT  100 OPERATION OF PLANT  101 OPERATION OF PLANT - HOSPITAL  102 OPERATION OF PLANT - HOSPITAL  103 OPERATION OF PLANT - TLMOB  104 LAUNDRY & LINEN SERVICE  105 DIETARY  106 CAFETERIA  107 CAFETERIA  108 ONURSING ADMINISTRATION  109 OPERATION OF PLANT - TLMOB  100 OF PLANT - TLMOB  100 OPERATION OF PLANT - TLMOB  100 OPERATION OF PLANT - TLMOB  100 OPERATION OF PLANT - SERVICE  100 OPERATION OF PLANT - TLMOB  100 OPERATION OF PLANT - SERVICE  100 OPERATION OF PLANT - TLMOB  100 OPERATI | 2, 300<br>88<br>24<br>0<br>9<br>84<br>0 | 2, 090<br>0<br>0<br>0<br>0  | 10, 694<br>1, 144<br>0<br>418<br>0           | 75, 404<br>0<br>0<br>0                                       | 563, 743<br>16, 732<br>0                          | 15. 00   |
| 30.00 030  | 000 ADULTS & PEDIATRICS  | 515                                     | 2, 090                      | 2, 348                                       | 41, 706  | 74, 798   | 30.00  |
| 1  | 100 INTENSIVE CARE UNIT<br>300 NURSERY   | 0                                       | 0                           | 0  | 0  | 0   | 31. 00<br>43. 00                               |
| ANC  | CILLARY SERVICE COST CENTERS   | 305                                     | 0                           | 780  | 8, 175   | 121, 477  | 50.00  |
| 52. 00 052<br>54. 00 054<br>55. 00 055<br>56. 00 036<br>57. 00 057<br>58. 00 058<br>60. 00 060 | DELIVERY ROOM & LABOR ROOM  ADDIOLOGY-DIAGNOSTIC  COO RADIOLOGY-THERAPEUTIC  ULTRA SOUND  COO CT SCAN  COO MAGNETIC RESONANCE IMAGING (MRI)  COO LABORATORY  | 0<br>82<br>9<br>6<br>9<br>12<br>121     | 0<br>0<br>0<br>0<br>0       | 0<br>562<br>95<br>80<br>472<br>192<br>1, 037 | 0<br>0<br>0<br>0<br>0<br>0                                   | 0<br>2, 299<br>618<br>3, 397<br>51, 931<br>6, 655 | 52. 00<br>54. 00<br>55. 00<br>56. 00<br>57. 00 |
| 1  | 500 PHYSI CAL THERAPY  | 91                                      | 0                           | 414  | 0  | 7, 784  | 66.00  |
|  | 700 OCCUPATI ONAL THERAPY<br>800 SPEECH PATHOLOGY  | 3                                       | 0                           | 106<br>70                                    | 0  | 251<br>0  | 67. 00<br>68. 00                               |
| 69. 00 069   | POO ELECTROCARDI OLOGY   | 0                                       | 0                           | 159  | 0  | 4, 482  | 1  |
| 1  | 100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS  | 0                                       | 0                           | 0  | 0  | 71, 109<br>5, 686                                 | 1  |
| 73. 00 073   | BOO DRUGS CHARGED TO PATIENTS  | 0                                       | 0                           | 0  | 0  | 0   | 73. 00   |
|  | BO1 ONCOLOGY DRUGS<br>D20 CARDI OPULMONARY   | 0<br>86                                 | 0                           | 0<br>646                                     | 0  | 0<br>17, 846                                      | 73. 01<br>76. 00                               |
| TUO  | PATIENT SERVICE COST CENTERS   |   | -1                          |  | -  |   |  |
|  | DOO CLINIC   | 44<br>334                               | 0                           | 209<br>1, 783                                |  | 6, 613<br>170, 544                                | 90.00  |
| 92. 00 092   | 200 OBSERVATION BEDS (NON-DISTINCT PART)   |   |                             |  |  |   | 92. 00   |
|  | 201 OBSERVATION BEDS (DISTINCT PART) HER REIMBURSABLE COST CENTERS   | 0                                       | 0                           | 0  | 0  | 0   | 92. 01   |
| 101.00 101   | 100 HOME HEALTH AGENCY   | 0                                       | 0                           | 0  | 0  | 0   | 101. 00  |
| 118. 00  | SUBTOTALS (SUM OF LINES 1 through 117)   | 1, 829                                  | 2, 090                      | 10, 515                                      | 75, 404  | 562, 222  | 118. 00  |
| 190. 00 190  | IREIMBURSABLE COST CENTERS DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0                                       | 0                           | 0  | 0  |   | 190. 00  |
|  | 100 RESEARCH<br>200 PHYSICIANS' PRIVATE OFFICES  | 0<br>102                                | 0                           | 0<br>179                                     | 0  |   | 191. 00<br>192. 00                             |
| 192. 00 192  |  | 369                                     | 0                           | 0  | 0  |   | 192. 00  |
|  | 203 ARNETT SURGERY OFFICE<br>201 OCCUPATIONAL MEDICINE   | 0                                       | 0                           | 0  | 0  |   | 192. 03<br>192. 04                             |
|  | NONPALD WORKERS  | 0                                       | 0                           | 0  | 0  |   | 192. 04  |
| 200. 00<br>201. 00   | Cross Foot Adjustments Negative Cost Centers   |   |                             |  |  |   | 200. 00<br>201. 00                             |
| 202. 00  | Cost to be allocated (per Wkst. B, Part I)   | 728, 261                                | 778, 755                    | 87, 416                                      | 1, 282, 492  | 1, 064, 029                                       |  |
| 203. 00<br>204. 00   | Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)   | 316. 635217<br>101, 808                 | 372. 610048<br>92, 547      | 8. 174303<br>23, 225                         |  | 1. 887436<br>225, 022                             | •  |
| 205. 00  | Unit cost multiplier (Wkst. B, Part  | 44. 264348                              | 44. 280861                  | 2. 171779                                    | 0. 642473  | 0. 399157   | 205. 00  |
| 206. 00  | NAHE adjustment amount to be allocated   |   |                             |  |  |   | 206. 00  |
| 207. 00  | (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,  |   |                             |  |  |   | 207. 00  |
|  | Parts III and IV)  |   | I                           |  |  |   | I  |

Health Financial Systems In Lieu of Form CMS-2552-10 IU HEALTH WHITE HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1312 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/25/2018 5: 20 pm Cost Center Description **PHARMACY** MEDI CAL (COSTED RECORDS & LI BRARY REQUIS.) (GROSS CHARGES) 15.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 1.02 1.02 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL 7.00 7.00 7.01 7.01 7.02 00702 OPERATION OF PLANT - TLMOB 7.02 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 1, 703, 880 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 0 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 290 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 04300 NURSERY 43.00 43.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 2,601 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2,898 0 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 8 0 55.00 56.00 03630 ULTRA SOUND 0 0 56.00 05700 CT SCAN 57.00 0 57.00 38 05800 MAGNETIC RESONANCE IMAGING (MRI) 58. 00 0 58.00 0 60.00 06000 LABORATORY 0 0 60.00 06600 PHYSI CAL THERAPY 14 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 69 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 429, 459 0 73.00 73.00 73. 01 07301 ONCOLOGY DRUGS 1, 248, 597 0 73.01 76.00 03020 CARDI OPULMONARY 0 76.00 434 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 145 0 90.00 91.00 09100 EMERGENCY 11, 305 91.00 DOCEDIATION DEDC (NON DICTINGT DADT) 00 )1 0

| 92.00  09200  | O OBSERVATION BEDS (NON-DISTINCT PART) |             |           |    | 92. 00  |
|---------------|--|-------------|-----------|----|---------|
| 92. 01 09201  | OBSERVATION BEDS (DISTINCT PART)       | 0           | 0         |    | 92. 01  |
| OTHER         | R REIMBURSABLE COST CENTERS            |             |           |    |         |
| 101. 00 10100 | HOME HEALTH AGENCY                     | 0           | 0         | 1  | 101. 00 |
| SPECI         | AL PURPOSE COST CENTERS                |             |           |    |         |
| 118. 00       | SUBTOTALS (SUM OF LINES 1 through 117) | 1, 703, 858 | 0         | 1  | 118. 00 |
|               | IMBURSABLE COST CENTERS                |             |           |    |         |
|               | GIFT, FLOWER, COFFEE SHOP & CANTEEN    | 0           | 0         |    | 190. 00 |
| 191. 00 19100 | RESEARCH                               | 0           | 0         |    | 191. 00 |
| 192. 00 19200 | PHYSICIANS' PRIVATE OFFICES            | 22          | 0         |    | 192. 00 |
| 192. 02 19202 | •                                      | 0           | 0         |    | 192. 02 |
|               | ARNETT SURGERY OFFICE                  | 0           | 0         |    | 192. 03 |
|               | OCCUPATIONAL MEDICINE                  | 0           | 0         |    | 192. 04 |
|               | NONPALD WORKERS                        | 0           | 0         |    | 193. 00 |
| 200. 00       | Cross Foot Adjustments                 |             |           | 2  | 200. 00 |
| 201. 00       | Negative Cost Centers                  |             |           |    | 201. 00 |
| 202. 00       | Cost to be allocated (per Wkst. B,     | 1, 051, 729 | 0         |    | 202. 00 |
|               | Part I)                                |             |           |    |         |
| 203. 00       | Unit cost multiplier (Wkst. B, Part I) | 0. 617255   | 0. 000000 |    | 203. 00 |
| 204. 00       | Cost to be allocated (per Wkst. B,     | 115, 425    | 0         | [2 | 204. 00 |
|               | Part II)                               |             |           |    |         |
| 205. 00       | Unit cost multiplier (Wkst. B, Part    | 0. 067742   | 0. 000000 | 2  | 205. 00 |
|               | 11)                                    |             |           |    |         |
| 206. 00       | NAHE adjustment amount to be allocated |             |           |    | 206. 00 |
| 207.00        | (per Wkst. B-2)                        |             |           |    | 207.00  |
| 207. 00       | NAHE unit cost multiplier (Wkst. D,    |             |           |    | 207. 00 |
|               | Parts III and IV)                      |             | I         |    |         |

| Health Financial Systems                 | IU HEALTH WHITE HOSPITAL | In Lieu of Form CMS-2552-10                   |
|--|--------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312    | Period: Worksheet C<br>From 01/01/2017 Part I |

|        |  |                |               |               | From 01/01/2017<br>To 12/31/2017 |                        |           |
|--------|--|----------------|---------------|---------------|----------------------------------|------------------------|-----------|
|        |  |                | Ti +Lo        | xVIII         | Hospi tal                        | 5/25/2018 5: 2<br>Cost | U pili    |
|        |  |                | 11110         | : AVIII       | Costs                            | COST                   |           |
|        | Cost Center Description                    | Total Cost     | Therapy Limit | Total Costs   | RCE                              | Total Costs            |           |
|        | cost center bescription                    | (from Wkst. B. | Adj.          | 10141 00313   | Di sal I owance                  | 10141 00313            |           |
|        |  | Part I, col.   | riag .        |               | Di Sai i Gilance                 |                        |           |
|        |  | 26)            |               |               |                                  |                        |           |
|        |  | 1.00           | 2. 00         | 3.00          | 4. 00                            | 5. 00                  |           |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     |                |               |               |                                  | 0.00                   |           |
|        | 03000 ADULTS & PEDIATRICS                  | 5, 494, 853    |               | 5, 494, 85    | 3 0                              | 0                      | 30.00     |
| 31.00  | 03100 INTENSIVE CARE UNIT                  | 0              |               |               | 0                                | 0                      | 31.00     |
| 43.00  | 04300 NURSERY                              | 0              |               |               | 0                                | 0                      | 43.00     |
|        | ANCILLARY SERVICE COST CENTERS             |                |               |               |                                  |                        | 1         |
| 50.00  | 05000 OPERATING ROOM                       | 2, 591, 950    |               | 2, 591, 95    | 0                                | 0                      | 50.00     |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM           | 0              |               |               | 0                                | 0                      | 52.00     |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 1, 083, 476    |               | 1, 083, 47    | 6 0                              | 0                      | 54.00     |
| 55.00  | 05500 RADI OLOGY-THERAPEUTI C              | 203, 795       |               | 203, 79       | 5 0                              | 0                      | 55.00     |
| 56.00  | 03630 ULTRA SOUND                          | 238, 274       |               | 238, 27       | 4 0                              | 0                      | 56.00     |
|        | 05700 CT SCAN                              | 611, 095       |               | 611, 09       | 5 0                              | 0                      | 57.00     |
| 58.00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 271, 559       |               | 271, 55       | 9 0                              | 0                      | 58. 00    |
| 60.00  | 06000 LABORATORY                           | 1, 882, 730    |               | 1, 882, 73    | 0                                | 0                      | 60.00     |
|        | 06600 PHYSI CAL THERAPY                    | 723, 318       | 0             | 723, 31       | 8 0                              | 0                      | 66. 00    |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 192, 922       | 0             | 192, 92       | 2 0                              | 0                      | 67. 00    |
|        | 06800 SPEECH PATHOLOGY                     | 124, 473       | 0             | 124, 47       |                                  | 0                      |           |
|        | 06900 ELECTROCARDI OLOGY                   | 317, 220       |               | 317, 22       | 0                                | 0                      | 69. 00    |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 160, 966       |               | 160, 96       |                                  | 0                      | 1 00      |
|        | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 17, 933        |               | 17, 93        | 3 0                              | 0                      | 1 . 2. 00 |
|        | 07300 DRUGS CHARGED TO PATIENTS            | 808, 965       |               | 808, 96       | 5 0                              | 0                      | 73. 00    |
|        | 07301 ONCOLOGY DRUGS                       | 2, 351, 961    |               | 2, 351, 96    | 1 0                              | 0                      | 73. 01    |
| 76.00  | 03020 CARDI OPULMONARY                     | 764, 765       |               | 764, 76       | 5 0                              | 0                      | 76. 00    |
|        | OUTPATIENT SERVICE COST CENTERS            |                |               |               |                                  |                        |           |
|        | 09000 CLI NI C                             | 431, 582       |               | 431, 58.      | 2 0                              | 0                      |           |
|        | 09100 EMERGENCY                            | 4, 569, 141    |               | 4, 569, 14    |                                  | 0                      |           |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 683, 088    |               | 1, 683, 08    | 8                                | 0                      |           |
| 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0              |               |               | 0                                | 0                      | 92. 01    |
|        | OTHER REIMBURSABLE COST CENTERS            |                |               |               |                                  |                        |           |
|        | 10100 HOME HEALTH AGENCY                   | 0              |               |               | 0                                |                        | 101. 00   |
| 200.00 |  | 24, 524, 066   | 0             | 2 1, 02 1, 00 |                                  |                        | 200. 00   |
| 201.00 |  | 1, 683, 088    |               | 1, 683, 08    |                                  |                        | 201. 00   |
| 202.00 | Total (see instructions)                   | 22, 840, 978   | 0             | 22, 840, 97   | 8 0                              | 0                      | 202. 00   |
|        |  |                |               |               |                                  |                        |           |

| Health Financial Systems                 | IU HEALTH WHITE HOSPITAL | In Lieu of Form CMS-2552-10 |
|--|--------------------------|-----------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1312   | Peri od: Worksheet C        |
|  |                          | From 01/01/2017   Part I    |
|  |                          | T- 10/01/0017 D-+-/T: D     |

|        |  |             |              |              | o 12/31/2017  | Date/Time Pre<br>5/25/2018 5:2 |         |
|--------|--|-------------|--------------|--------------|---------------|--------------------------------|---------|
|        |  | _           | Title        | XVIII        | Hospi tal     | Cost                           |         |
|        |  |             | Charges      |              |               |                                |         |
|        | Cost Center Description                    | I npati ent | Outpati ent  |              | Cost or Other | TEFRA                          |         |
|        |  |             |              | + col. 7)    | Ratio         | Inpati ent                     |         |
|        |  |             |              |              |               | Rati o                         |         |
|        |  | 6. 00       | 7. 00        | 8. 00        | 9. 00         | 10. 00                         |         |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     | 0.440.050   |              |              |               |                                |         |
|        | 03000 ADULTS & PEDI ATRI CS                | 3, 160, 850 |              | 3, 160, 850  | )             |                                | 30. 00  |
|        | 03100 INTENSIVE CARE UNIT                  | 0           |              | (            | )             |                                | 31. 00  |
| 43.00  | 04300 NURSERY                              | 0           |              |              | )             |                                | 43. 00  |
|        | ANCILLARY SERVICE COST CENTERS             | 10 700      | 7 050 100    | 7 005 406    | 0.055007      | 2 22222                        |         |
|        | 05000 OPERATING ROOM                       | 42, 788     | 7, 252, 400  |              |               | 0. 000000                      |         |
|        | 05200 DELIVERY ROOM & LABOR ROOM           | 0           | 0            | 1            | 0.00000       | 0. 000000                      |         |
|        | 05400 RADI OLOGY-DI AGNOSTI C              | 73, 883     | 5, 171, 383  |              |               | 0. 000000                      |         |
|        | 05500 RADI OLOGY-THERAPEUTI C              | 0           | 942, 633     |              |               | 0. 000000                      |         |
|        | 03630 ULTRA SOUND                          | 74, 052     | 1, 729, 750  |              |               | 0. 000000                      |         |
| 57. 00 | 05700 CT SCAN                              | 179, 417    | 4, 357, 433  |              |               | 0. 000000                      |         |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 47, 932     | 1, 114, 481  |              |               | 0. 000000                      |         |
|        | 06000 LABORATORY                           | 761, 030    | 6, 136, 418  |              |               | 0. 000000                      |         |
|        | 06600 PHYSI CAL THERAPY                    | 387, 339    | 1, 042, 576  |              |               | 0. 000000                      |         |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY                | 178, 541    | 128, 556     |              |               | 0. 000000                      | 1       |
|        | 06800 SPEECH PATHOLOGY                     | 36, 324     | 144, 871     |              |               | 0. 000000                      |         |
|        | 06900 ELECTROCARDI OLOGY                   | 305, 568    | 3, 619, 270  |              |               | 0. 000000                      |         |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 12, 669     | 448, 850     |              |               | 0. 000000                      |         |
|        | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0           | 137, 764     |              |               | 0. 000000                      |         |
|        | 07300 DRUGS CHARGED TO PATIENTS            | 1, 823, 318 | 4, 943, 024  |              |               | 0. 000000                      |         |
|        | 07301 ONCOLOGY DRUGS                       | 0           | 3, 832, 777  |              |               | 0. 000000                      | 1       |
| 76. 00 | 03020 CARDI OPULMONARY                     | 372, 446    | 501, 838     | 874, 284     | 0. 874733     | 0. 000000                      | 76. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |             |              | 1            |               |                                |         |
|        | 09000 CLI NI C                             | 0           | 983, 710     |              |               | 0. 000000                      | 1       |
|        | 09100 EMERGENCY                            | 274, 192    | 16, 760, 070 |              |               | 0. 000000                      |         |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 10, 585     | 4, 579, 974  |              |               | 0. 000000                      |         |
| 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0           | 0            | (            | 0. 000000     | 0. 000000                      | 92. 01  |
|        | OTHER REIMBURSABLE COST CENTERS            |             |              |              |               |                                |         |
|        | 10100 HOME HEALTH AGENCY                   | 0           | 0            | 1            |               |                                | 101. 00 |
| 200.00 |  | 7, 740, 934 | 63, 827, 778 | 71, 568, 712 | 2             |                                | 200. 00 |
| 201.00 | l l  |             |              |              |               |                                | 201. 00 |
| 202.00 | Total (see instructions)                   | 7, 740, 934 | 63, 827, 778 | 71, 568, 712 | 2             |                                | 202. 00 |

| Health Financial Systems                 | IU HEALTH WHITE HOSPITAL | In Lieu of Form CMS-2552-10  |
|--|--------------------------|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1312   | Peri od: Worksheet C<br>From 01/01/2017<br>To 12/31/2017 Part I<br>Date/Time Prepared: 5/25/2018 5:20 pm |

| Title XVIII  |        |  |           |             |           | 5/25/2018 5: 20 | ) pm    |
|--|--------|--|-----------|-------------|-----------|-----------------|---------|
| Ratio   11.00  |        |  |           | Title XVIII | Hospi tal | Cost            |         |
| 11.00  |        | Cost Center Description                    |           |             |           |                 |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   30.00   30.00   ADULTS & PEDIATRICS   31.00   O3100   INTENSIVE CARE UNIT   31.00   43.00   04300   NURSERY   43.00 |        |  |           |             |           |                 |         |
| 30. 00   03000   ADULTS & PEDI ATRI CS   30. 00   31. 00   03100   I NTENSI VE CARE UNI T   31. 00   43. 00   04300   NURSERY   43. 00                       |        |  | 11. 00    |             |           |                 |         |
| 31. 00   03100   INTENSI VE CARE UNI T   31. 00   43. 00   04300   NURSERY   43. 00  |        |  |           |             |           |                 | l       |
| 43. 00 04300 NURSERY 43. 00  |        |  |           |             |           |                 |         |
|  |        |  |           |             |           |                 | 31. 00  |
| ANCILLARY SERVICE COST CENTERS   | 43.00  |  |           |             |           |                 | 43. 00  |
|  |        |  |           |             |           |                 | l       |
|  |        |  |           |             |           |                 | 50.00   |
|  | 52.00  |  | 0. 000000 |             |           |                 | 52. 00  |
|  | 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              |           |             |           |                 | 54. 00  |
| 55. 00   05500   RADI 0LOGY-THERAPEUTI C 0. 000000   55. 00  | 55.00  | 05500 RADI OLOGY-THERAPEUTI C              | 0. 000000 |             |           |                 | 55. 00  |
| 56. 00   03630   ULTRA SOUND   0. 000000   56. 00  | 56.00  | 03630 ULTRA SOUND                          | 0. 000000 |             |           |                 | 56. 00  |
| 57. 00   05700   CT SCAN   0. 000000   57. 00  | 57.00  | 05700 CT SCAN                              | 0. 000000 |             |           |                 | 57. 00  |
| 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.000000   58.00  | 58.00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0. 000000 |             |           |                 | 58. 00  |
| 60. 00   06000   LABORATORY   0. 000000   60. 00   | 60.00  | 06000 LABORATORY                           | 0. 000000 |             |           |                 | 60.00   |
| 66. 00   06600   PHYSI CAL THERAPY 0. 000000   66. 00  | 66.00  | 06600 PHYSI CAL THERAPY                    | 0. 000000 |             |           |                 | 66. 00  |
| 67. 00   06700   0CCUPATI ONAL THERAPY 0. 000000   67. 00  | 67.00  | 06700 OCCUPATI ONAL THERAPY                | 0. 000000 |             |           |                 | 67. 00  |
| 68. 00   06800   SPEECH PATHOLOGY   0. 000000   68. 00   | 68.00  | 06800 SPEECH PATHOLOGY                     | 0. 000000 |             |           |                 | 68. 00  |
| 69. 00   06900   ELECTROCARDI OLOGY 0. 000000   69. 00   | 69.00  | 06900 ELECTROCARDI OLOGY                   | 0. 000000 |             |           |                 | 69. 00  |
| 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0.000000   71. 00   | 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 |             |           |                 | 71. 00  |
| 72.00   07200   I MPL. DEV. CHARGED TO PATIENTS   0.000000   72.00   | 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0. 000000 |             |           |                 | 72. 00  |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   73.00  | 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000 |             |           |                 | 73. 00  |
| 73. 01   07301   0NCOLOGY DRUGS   0. 000000   73. 01   | 73. 01 | 07301 ONCOLOGY DRUGS                       | 0. 000000 |             |           |                 | 73. 01  |
| 76. 00   03020   CARDI OPULMONARY 0. 000000   76. 00   | 76.00  | 03020 CARDI OPULMONARY                     | 0. 000000 |             |           |                 | 76. 00  |
| OUTPATIENT SERVICE COST CENTERS  |        |  |           |             |           |                 | l       |
| 90. 00   09000   CLI NI C   0. 000000   90. 00   | 90.00  | 09000 CLI NI C                             | 0. 000000 |             |           |                 | 90. 00  |
| 91. 00   09100   EMERGENCY   0. 000000   91. 00  | 91.00  | 09100 EMERGENCY                            | 0. 000000 |             |           |                 | 91. 00  |
| 92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0.000000   92. 00   | 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 |             |           |                 | 92.00   |
| 92. 01   09201   0BSERVATI ON BEDS (DI STI NCT PART) 0. 000000   92. 01  | 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0. 000000 |             |           |                 | 92. 01  |
| OTHER REIMBURSABLE COST CENTERS  |        | OTHER REIMBURSABLE COST CENTERS            |           |             |           |                 |         |
| 101. 00 10100 HOME HEALTH AGENCY 101. 00   | 101.00 | 10100 HOME HEALTH AGENCY                   |           |             |           |                 | 101. 00 |
| 200.00 Subtotal (see instructions) 200.00  | 200.00 | Subtotal (see instructions)                |           |             |           |                 | 200. 00 |
| 201.00 Less Observation Beds 201.00  | 201.00 | Less Observation Beds                      |           |             |           |                 | 201. 00 |
| 202.00   Total (see instructions)   202.00   | 202.00 | Total (see instructions)                   |           |             |           |                 | 202. 00 |

| Health Financial Systems                 | IU HEALTH WHITE HOSPITAL | In Lie                                       | u of Form CMS-2552-10   |
|--|--------------------------|--|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1312   | Peri od:<br>From 01/01/2017<br>To 12/31/2017 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>5/25/2018 5:20 pm |
|  | Title XIX                | Hospi tal                                    | Cost  |

|           |  |                |               |               | To 12/31/2017   | Date/Time Pre 5/25/2018 5:2 |         |
|-----------|--|----------------|---------------|---------------|-----------------|-----------------------------|---------|
|           |  |                | Ti tl         | e XIX         | Hospi tal       | Cost                        |         |
|           |  |                |               |               | Costs           |                             |         |
|           | Cost Center Description                  | Total Cost     | Therapy Limit | Total Costs   | RCE             | Total Costs                 |         |
|           |  | (from Wkst. B, | Adj .         |               | Di sal I owance |                             |         |
|           |  | Part I, col.   |               |               |                 |                             |         |
|           |  | 26)            |               |               |                 |                             |         |
|           |  | 1.00           | 2. 00         | 3. 00         | 4. 00           | 5. 00                       |         |
|           | PATIENT ROUTINE SERVICE COST CENTERS     | ,              |               |               |                 |                             | 1       |
|           | 000 ADULTS & PEDIATRICS                  | 5, 494, 853    |               | 5, 494, 85    |                 | 0, 1, 1, 000                |         |
|           | 100 INTENSIVE CARE UNIT                  | 0              |               |               | 0               | _                           |         |
|           | 300 NURSERY                              | 0              |               |               | 0 0             | 0                           | 43. 00  |
|           | CILLARY SERVICE COST CENTERS             | 1              |               |               |                 | T                           |         |
|           | 000 OPERATING ROOM                       | 2, 591, 950    |               | 2, 591, 95    | 50 0            | 2,0,1,,00                   |         |
|           | 200 DELIVERY ROOM & LABOR ROOM           | 0              |               |               | 0               | 0                           | 52.00   |
|           | 400 RADI OLOGY-DI AGNOSTI C              | 1, 083, 476    |               | 1, 083, 47    |                 | 1, 083, 476                 | 1       |
|           | 500 RADI OLOGY-THERAPEUTI C              | 203, 795       |               | 203, 79       |                 | 203, 795                    | 1       |
|           | 630 ULTRA SOUND                          | 238, 274       |               | 238, 27       |                 | 238, 274                    | 1       |
|           | 700 CT SCAN                              | 611, 095       |               | 611, 09       |                 | 611, 095                    |         |
|           | 800 MAGNETIC RESONANCE IMAGING (MRI)     | 271, 559       |               | 271, 55       |                 | 271, 559                    |         |
|           | 000 LABORATORY                           | 1, 882, 730    |               | 1, 882, 73    |                 | 1, 882, 730                 |         |
|           | 600 PHYSI CAL THERAPY                    | 723, 318       | 0             | , 20, 0       |                 | 723, 318                    | 1       |
|           | 700 OCCUPATI ONAL THERAPY                | 192, 922       | 0             | 192, 92       |                 | 192, 922                    | 1       |
|           | 800 SPEECH PATHOLOGY                     | 124, 473       | 0             | 124, 47       |                 | 124, 473                    | 1       |
|           | 900 ELECTROCARDI OLOGY                   | 317, 220       |               | 317, 22       |                 | 317, 220                    | 1       |
|           | 100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 160, 966       |               | 160, 96       | 66 0            | 160, 966                    |         |
|           | 200 IMPL. DEV. CHARGED TO PATIENTS       | 17, 933        |               | 17, 93        | 33 0            | 17, 933                     | 72. 00  |
| 73.00 07: | 300 DRUGS CHARGED TO PATIENTS            | 808, 965       |               | 808, 96       | 55 0            | 808, 965                    | 73. 00  |
|           | 301 ONCOLOGY DRUGS                       | 2, 351, 961    |               | 2, 351, 96    | 51 0            | 2, 351, 961                 | 73. 01  |
|           | 020 CARDI OPULMONARY                     | 764, 765       |               | 764, 76       | 55 0            | 764, 765                    | 76. 00  |
|           | TPAȚIENT SERVICE COST CENTERS            |                |               |               |                 |                             |         |
|           | DOO CLI NI C                             | 431, 582       |               | 431, 58       | 32 0            | 431, 582                    | 90. 00  |
|           | 100 EMERGENCY                            | 4, 569, 141    |               | 4, 569, 14    | 11 0            | 4, 569, 141                 | 91.00   |
|           | 200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 683, 088    |               | 1, 683, 08    | 38              | 1, 683, 088                 |         |
|           | 201 OBSERVATION BEDS (DISTINCT PART)     | 0              |               |               | 0 0             | 0                           | 92. 01  |
|           | HER REIMBURSABLE COST CENTERS            |                |               |               |                 |                             |         |
| 1         | 100 HOME HEALTH AGENCY                   | 0              |               |               | 0               |                             | 101. 00 |
| 200. 00   | Subtotal (see instructions)              | 24, 524, 066   | 0             | 2 1, 02 1, 00 |                 | ,,                          |         |
| 201. 00   | Less Observation Beds                    | 1, 683, 088    |               | 1, 683, 08    |                 | 1, 683, 088                 | 1       |
| 202. 00   | Total (see instructions)                 | 22, 840, 978   | 0             | 22, 840, 97   | 78 0            | 22, 840, 978                | 202. 00 |

| IU HEALTH WHITE HOSPITAL | In Lie                | u of Form CMS-2552-10 |
|--------------------------|-----------------------|-----------------------|
| Provi der CCN: 15-1312   | Peri od:              | Worksheet C           |
|                          |                       |                       |
|                          | Provider CCN: 15-1312 |                       |

|        |  |             |              |              | o 12/31/2017  | Date/Time Pre<br>5/25/2018 5:2 |         |
|--------|--|-------------|--------------|--------------|---------------|--------------------------------|---------|
|        |  | _           | Ti tl        | e XIX        | Hospi tal     | Cost                           |         |
|        |  |             | Charges      |              |               |                                |         |
|        | Cost Center Description                    | I npati ent | Outpati ent  |              | Cost or Other | TEFRA                          |         |
|        |  |             |              | + col. 7)    | Ratio         | Inpati ent                     |         |
|        |  |             |              |              |               | Ratio                          |         |
|        |  | 6. 00       | 7. 00        | 8. 00        | 9. 00         | 10. 00                         |         |
|        | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 0.440.050   |              |              | 1             |                                |         |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS                | 3, 160, 850 |              | 3, 160, 850  |               | I                              | 30.00   |
|        | 03100   I NTENSI VE CARE UNI T             | 0           |              |              | )             | I                              | 31.00   |
| 43.00  | 04300 NURSERY                              | 0           |              |              |               |                                | 43. 00  |
|        | ANCILLARY SERVICE COST CENTERS             | 10 700      | 7 050 400    | 7 005 406    | 0.05500/      |                                |         |
|        | 05000 OPERATI NG ROOM                      | 42, 788     | 7, 252, 400  |              |               | 0. 000000                      |         |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM           | 0           | 0            | 1            | 0.00000       |                                |         |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 73, 883     | 5, 171, 383  |              |               | 0.000000                       |         |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C              | 0           | 942, 633     |              |               |                                |         |
| 56. 00 | 03630 ULTRA SOUND                          | 74, 052     | 1, 729, 750  |              |               | 0. 000000                      |         |
| 57. 00 | 05700 CT SCAN                              | 179, 417    | 4, 357, 433  |              |               | 0. 000000                      |         |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 47, 932     | 1, 114, 481  |              |               | 0. 000000                      |         |
|        | 06000 LABORATORY                           | 761, 030    | 6, 136, 418  |              |               | 0. 000000                      |         |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 387, 339    | 1, 042, 576  |              |               | 0. 000000                      |         |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY                | 178, 541    | 128, 556     |              |               | 0. 000000                      |         |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 36, 324     | 144, 871     |              |               |                                |         |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 305, 568    | 3, 619, 270  |              |               | 0. 000000                      |         |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 12, 669     | 448, 850     |              |               | 0. 000000                      |         |
|        | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0           | 137, 764     |              |               | 0. 000000                      |         |
|        | 07300 DRUGS CHARGED TO PATIENTS            | 1, 823, 318 | 4, 943, 024  |              |               | 0. 000000                      |         |
|        | 07301 ONCOLOGY DRUGS                       | 0           | 3, 832, 777  |              |               | 0. 000000                      |         |
| 76. 00 | 03020 CARDI OPULMONARY                     | 372, 446    | 501, 838     | 874, 284     | 0. 874733     | 0. 000000                      | 76. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |             |              |              |               |                                |         |
|        | 09000 CLI NI C                             | 0           | 983, 710     |              |               | 0. 000000                      |         |
| 91. 00 | 09100 EMERGENCY                            | 274, 192    | 16, 760, 070 |              |               | 0. 000000                      |         |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 10, 585     | 4, 579, 974  | 4, 590, 559  |               | 0. 000000                      |         |
| 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0           | 0            | (            | 0. 000000     | 0. 000000                      | 92. 01  |
|        | OTHER REIMBURSABLE COST CENTERS            |             |              |              |               |                                |         |
|        | 10100 HOME HEALTH AGENCY                   | 0           | 0            | _            |               | ı                              | 101. 00 |
| 200.00 |  | 7, 740, 934 | 63, 827, 778 | 71, 568, 712 |               | I                              | 200. 00 |
| 201.00 | 1  |             |              |              |               | I                              | 201. 00 |
| 202.00 | Total (see instructions)                   | 7, 740, 934 | 63, 827, 778 | 71, 568, 712 |               | ı                              | 202. 00 |

| Health Financial Systems                 | IU HEALTH WHITE HOSPITAL | In Lie                                       | u of Form CMS-2552-10   |
|--|--------------------------|--|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1312   | Peri od:<br>From 01/01/2017<br>To 12/31/2017 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>5/25/2018 5:20 pm |

| Title XIX  |   |                 |           | 12, 31, 231, | 5/25/2018 5: 20 pm |
|--|---|-----------------|-----------|--------------|--------------------|
| NPATI ENT ROUTI NE SERVICE COST CENTERS   11.00  |   |                 | Title XIX | Hospi tal    | Cost               |
| NPATI ENT ROUTINE SERVICE COST CENTERS   30. 00   03000   ADULTS & PEDI ATRI CS   31. 00   03100   INTENSI VE CARE UNIT   31. 00   03100   INTENSI VE CARE UNIT   31. 00   03100   INTENSI VE CARE UNIT   31. 00   03100   NURSERY   43. 00   03000   NURSERY   43. 00   03000   NURSERY   43. 00   03000   OPERATI NO ROOM   0. 000000   052. 00   052.00   DELI VERY ROOM & LABOR ROOM   0. 000000   52. 00   052.00   DELI VERY ROOM & LABOR ROOM   0. 000000   52. 00   055. 00   055.00     | Cost Center Description                     | PPS Inpatient   |           |              |                    |
| INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   300   30100   INTERNS VE CARE UNIT   31.00   31.00   31.00   INTERNS VE CARE UNIT   31.00   43.00   43.00   A30.00   INTERNS VE CARE UNIT   31.00   A30.00   A30.00   INTERNS VE CARE UNIT   31.00   A30.00   A30.00   INTERNS VE CARE UNIT   31.00   A30.00   A30.00   INTERNS VE CARE UNIT   33.00   A30.00   A30.00   INTERNS VE CARE UNIT   33.00   A30.00   A30.00   INTERNS VE CARE UNIT   33.00   A30.00   A30.00   INTERNS VE CONTROL OF   |   | Ratio           |           |              |                    |
| 30. 00   03000   ADULTS & PEDIATRICS   30. 00   31. 00   31. 00   03100   INTENSIVE CARE UNIT   31. 00   31.    |   | 11. 00          |           |              |                    |
| 31. 00   |   | RS              |           |              |                    |
| 43. 00   0.300   NURSERY   |   |                 |           |              | 30.00              |
| ANCILLARY SERVICE COST CENTERS   |   |                 |           |              | 31.00              |
| 50, 00   05000   DERATTING RODM   0,000000   52,00   0520   DELIVERY ROOM & LABOR ROOM   0,000000   55,00   05400   RADI OLOGY-DI AGNOSTI C   0,000000   55,00   05500   RADI OLOGY-THERAPEUTI C   0,000000   55,00   05500   RADI OLOGY-THERAPEUTI C   0,000000   55,00   05500   RADI OLOGY-THERAPEUTI C   0,000000   55,00   057,00   05700   CT SCAN   0,0000000   0,0000000   0,0000000   0,0000000   0,00000000  |   |                 |           |              | 43. 00             |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM   0.000000   0.54.00   0.5400   RADI OLOGY-DI AGNOSTI C   0.000000   0.55.00   0.00500   RADI OLOGY-THERAPEUTI C   0.000000   0.55.00   0.00500   0.00500   RADI OLOGY-THERAPEUTI C   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000  |   |                 |           |              |                    |
| 54. 00       05400 RADI OLOGY-DI AGNOSTIC       0.000000       55. 00         55. 00       05500 RADI OLOGY-THERAPEUTIC       0.000000       55. 00         56. 00       03630 ULTRA SOUND       0.000000       56. 00         57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0.000000       58. 00         60. 00       06000 LABORATORY       0.000000       60. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71. 00         72. 00       07200 I MPL DEV. CHARGED TO PATI ENTS       0.000000       72. 00         73. 01       07301 ONCOLOGY DRUGS       0.000000       73. 00         73. 01       07301 ONCOLOGY DRUGS       0.000000       76. 00         00       09000 CLINIC       0.000000       90. 00         91. 00       09100 EMERGENCY       0.000000       92. 00  |   | 0. 000000       |           |              | 50.00              |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000  | 52.00   05200   DELIVERY ROOM & LABOR ROOM  | 0. 000000       |           |              | 52. 00             |
| 56. 00   03630   ULTRA SOUND   0.000000   57. 00   57. 00   57. 00   57. 00   57. 00   57. 00   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.000000   58. 00   06000   LABORATORY   0.000000   60. 00   06600   PHYSI CAL THERAPY   0.000000   67. 00   06600   PHYSI CAL THERAPY   0.000000   68. 00   06800   SPEECH PATHOLOGY   0.000000   68. 00   06800   SPEECH PATHOLOGY   0.000000   69. 00    | 54. 00   05400 RADI OLOGY-DI AGNOSTI C      | 0. 000000       |           |              | 54.00              |
| 57. 00   | 55. 00   05500 RADI OLOGY-THERAPEUTI C      | 0. 000000       |           |              | 55. 00             |
| 58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000  | 56.00 03630 ULTRA SOUND                     | 0. 000000       |           |              | 56.00              |
| 60. 00   | 57.00 05700 CT SCAN                         | 0. 000000       |           |              | 57. 00             |
| 66. 00   | 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI | 0.000000        |           |              | 58.00              |
| 67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   67. 00   68. 00   06800   SPECH PATHOLOGY   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.000000   69. 00   71. 00   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   72. 00   73. 00   73. 00   7300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   73. 01   07301   ONCOLOGY DRUGS   0.000000   73. 01   76. 00   03020   CARDI OPULMONARY   0.000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   76. 00   000000   000000   000000   000000   000000  | 60. 00   06000   LABORATORY                 | 0. 000000       |           |              | 60.00              |
| 68. 00   | 66. 00 06600 PHYSI CAL THERAPY              | 0. 000000       |           |              | 66. 00             |
| 69. 00   | 67. 00 06700 OCCUPATI ONAL THERAPY          | 0. 000000       |           |              | 67. 00             |
| 71. 00   | 68.00 06800 SPEECH PATHOLOGY                | 0. 000000       |           |              | 68. 00             |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   73. 00   73. 00   73. 00   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   74. 00   74. 0 | 69. 00 06900 ELECTROCARDI OLOGY             | 0. 000000       |           |              | 69. 00             |
| 73. 00 73. 01 73. 01 73. 01 73. 01 73. 01 76. 00 03020 CARDI OPULMONARY 0. 000000  0UTPATIENT SERVICE COST CENTERS  90. 00 91. 00 91. 00 92. 00 92. 00 92. 01 073. 01 073. 01 073. 01 073. 01 073. 01 073. 01 073. 01 073. 01 073. 01 074. 00 075. 00  | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT | TENTS 0. 000000 |           |              | 71. 00             |
| 73. 01 76. 00 03020 CARDI OPULMONARY 0. 000000  0UTPATIENT SERVICE COST CENTERS  90. 00 90100 EMERGENCY 0. 000000 92. 00 92. 00 92. 01 0THER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 200. 00 201. 00 Less Observation Beds  73. 01 76. 00 76. 00 76. 00 77. 00 76. 00 76. 00 77. 00  | 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 0. 000000       |           |              | 72. 00             |
| 76. 00   03020   CARDI OPULMONARY   0.000000   76. 00  | 73.00 07300 DRUGS CHARGED TO PATIENTS       | 0. 000000       |           |              | 73. 00             |
| OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   0.000000   91.00   91.00   09100   EMERGENCY   0.000000   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   92.00   09201   OBSERVATION BEDS (DISTINCT PART)   0.000000   92.01   OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME HEALTH AGENCY   101.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00  | 73. 01   07301   0NCOLOGY DRUGS             | 0. 000000       |           |              | 73. 01             |
| 90. 00   990.00   09000   CLINIC   0.000000   91. 00   92. 00   09200   08SERVATION BEDS (NON-DISTINCT PART)   0.000000   92. 00   09201   08SERVATION BEDS (DISTINCT PART)   0.000000   92. 01   07HER REIMBURSABLE COST CENTERS   101. 00   10100   HOME HEALTH AGENCY   101. 00   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   201.  | 76. 00 03020 CARDI OPULMONARY               | 0. 000000       |           |              | 76. 00             |
| 91. 00   09100   EMERGENCY   0. 000000   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 000000   92. 00   09201   OBSERVATION BEDS (DISTINCT PART)   0. 000000   92. 01   OTHER REIMBURSABLE COST CENTERS   101. 00   10100   HOME HEALTH AGENCY   101. 00   Company of the company of  | OUTPATIENT SERVICE COST CENTERS             |                 |           |              |                    |
| 92. 00   09200   095ERVATION BEDS (NON-DISTINCT PART)   0.000000   92. 01   09201   095ERVATION BEDS (DISTINCT PART)   0.000000   92. 01   071HER REIMBURSABLE COST CENTERS   101. 00   10100   HOME HEALTH AGENCY   101. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00   | 90. 00 09000 CLI NI C                       | 0. 000000       |           |              | 90.00              |
| 92. 01   09201   0BSERVATI ON BEDS (DISTINCT PART)   0.000000   92. 01   | 91. 00   09100   EMERGENCY                  | 0. 000000       |           |              | 91.00              |
| OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME   HEALTH   AGENCY   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation   Beds   201.00  | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT  | PART) 0. 000000 |           |              | 92. 00             |
| 101.00   | 92.01 09201 OBSERVATION BEDS (DISTINCT PART | 0.000000        |           |              | 92. 01             |
| 200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00  | OTHER REIMBURSABLE COST CENTERS             |                 |           |              |                    |
| 201.00 Less Observation Beds 201.00  | 101.00 10100 HOME HEALTH AGENCY             |                 |           |              | 101. 00            |
|  | 200.00 Subtotal (see instructions)          |                 |           |              | 200. 00            |
| 202. 00   Total (see instructions)   202. 00   | 201.00 Less Observation Beds                |                 |           |              | 201. 00            |
|  | 202.00 Total (see instructions)             |                 |           |              | 202. 00            |

| Health Financial Systems     |                           | IU HEALTH WHITE | HOSPI TAL             | In Lie   | u of Form CMS-2552-10 |
|------------------------------|---------------------------|-----------------|-----------------------|----------|-----------------------|
| APPORTIONMENT OF INPATIENT A | ANCILLARY SERVICE CAPITAL | COSTS           | Provider CCN: 15-1312 | Peri od: | Worksheet D           |

| APPORTI ONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS   Provider CCN: 15-1312   Provider CCN:    | Health Financial Systems                            | IU HEALTH WHI | TE HOSPITAL    |          | In Lie        | u of Form CMS-2 | 2552-10 |
|--|---|---------------|----------------|----------|---------------|-----------------|---------|
| Cost Center Description  | APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS      | Provi der C    |          |               |                 |         |
| Cost Center Description  |   |               |                |          |               |                 |         |
| Capital   Capital   Related Cost   (From Wkst. C, Part I, col.   Related Cost   (From Wkst. C, Col.   |   |               |                |          | To 12/31/2017 |                 |         |
| Capit al Related Cost (from Wkst. B, Part I, col. (from Wkst. B, Part I), col. (a)   Col. 1 + col. (b)   Col. 1 + col. (col. m)   Col.   |   |               | T' 11          | 20/11/1  |               |                 | U pm    |
| Related Cost   (From Wkst. C)   (From Wkst. E)   (From Wkst. C)   (From Wkst. E)   (From Kkst. E)   (From Kkst. E)   (From Kkst. E)   (From Kkst. E)   (From Kkt. E)    |   |               |                |          |               |                 |         |
| CFrom Wikst B, Part I, col.   Col.   1 + col.   Charges   Column 4)   Part II, col.   26)   Charges   Column 4)   Part III, col.   26)   Charges   Column 4)   Charges   Column 4)   Part III, col.   26)   Charges   Charg   | Cost Center Description                             |               |                |          |               |                 |         |
| Part II, col. 26)   26)   26)   26)   20   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   5.00   3.00   4.00   5.00     |   |               |                |          |               |                 |         |
| ANCILLARY SERVICE COST CENTERS   |   |               |                |          | . Charges     | column 4)       |         |
| ANCI LLARY SERVI CE COST CENTERS   |   |               | 8)             | 2)       |               |                 |         |
| ANCI LLARY SERVI CE COST CENTERS   50.00   05000   OPERATI ING ROOM   662,096   7,295,188   0.090758   19,566   1,776   50.00   52.00   05000   DELYRATI ING ROOM   0   0   0.0000000   0   0   52.00   05000   DELYRATI ING ROOM   0   0   0.0000000   0   0   52.00   05000   DELYRATI ING ROOM   0   0   0.0000000   0   0   52.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   05.00   0.0000000   0   0   0.0000000   0  |   |               | 0.00           | 0.00     | 4.00          | F 00            |         |
| 50. 00         05000   OPERATI NG ROOM         662, 096         7, 295, 188         0.090758         19, 566         1, 776         50. 00           52. 00         05200   DELI VERY ROOM & LABOR ROOM         0         0.000000         0         0.000000         0         52. 00           54. 00         05400   RADI OLOGY-DI AGNOSTI C         280, 664         5, 245, 266         0.05508         27, 311         1, 461         54. 00           55. 00         05500   RADI OLOGY-THERAPEUTI C         33, 224         942, 633         0.035246         0         0         55. 00           56. 00         03630   ULTRA SOUND         25, 523         1, 803, 802         0.014150         44, 835         634         56. 00           58. 00         05800   MAGNETI C RESONANCE I MAGI NG (MRI)         46, 422         1, 162, 413         0.039936         20, 130         804         58. 00           60. 00         06000   LABORATORY         179, 671         6, 897, 448         0.026049         384, 402         10, 013         60. 00           66. 00         06600   PHYSI CAL THERAPY         143, 919         1, 429, 915         0.100649         113, 127         11, 386         66. 00           67. 00         06700   OCCUPATI ONAL THERAPY         13, 530         307, 097         <  | ANOTHER ABOVE OF BUILDING                           | 1.00          | 2.00           | 3.00     | 4.00          | 5.00            |         |
| 52. 00         05200         DELIVERY ROOM & LABOR ROOM         0         0         0.000000         0         0.000000         0         52. 00         55. 00         55. 00         0.05400 RADI OLOGY-DI AGNOSTI C         280, 664         5, 245, 266         0.055508         27, 311         1, 461         54. 00         0         0.05500 RADI OLOGY-DI AGNOSTI C         33, 224         942, 633         0.035246         0         0         0         55. 00         0         0.05500 RADI OLOGY-THERAPEUTI C         33, 224         942, 633         0.035246         0         0         0         55. 00         0         0.05500 RADI OLOGY-THERAPEUTI C         33, 224         942, 633         0.035246         0         0         0         55. 00         55. 00         0         0         0         55. 00         0         0         55. 00         0         0         0         55. 00         0         0         0         0         55. 00           |   |               |                | T        |               |                 |         |
| 54. 00         05400         RADI OLOGY-DI AGNOSTI C         280, 664         5, 245, 266         0.053508         27, 311         1, 461         54. 00           55. 00         05500         RADI OLOGY-THERAPEUTI C         33, 224         942, 633         0.035246         0         0         0         55. 00           56. 00         05303         ULTRA SOUND         25, 523         1, 803, 802         0.014150         44, 835         634         56. 00           57. 00         05700         CT SCAN         57, 483         4, 536, 850         0.012670         51, 764         656 57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         46, 422         1, 162, 413         0.039936         20, 130         804         58. 00           60. 00         06000         LABORATORY         179, 671         6, 897, 448         0.026049         384, 402         10, 013         60. 00           66. 00         06600         PHYSI CAL THERAPY         143, 919         1, 429, 915         0.100649         113, 127         11, 386         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         13, 530         307, 097         0.044058         47, 570         2, 096         67. 00           <  |   | 662, 096      | 7, 295, 188    | 1        |               |                 |         |
| 55. 00   |   | 0             | 0              |          |               |                 |         |
| 56. 00   |   | 1             |                |          |               |                 |         |
| 57. 00         05700         CT SCAN         57, 483         4, 536, 850         0.012670         51, 764         656         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         46, 422         1, 162, 413         0.039936         20, 130         804         58. 00           60. 00         06000         LABORATORY         179, 671         6, 897, 448         0.026049         384, 402         10, 013         60. 00           66. 00         06600         PHYSI CAL THERAPY         143, 919         1, 429, 915         0. 100649         113, 127         11, 386         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         13, 530         307, 097         0. 044058         47, 570         2, 096         67. 00           68. 00         06800         SPEECH PATHOLOGY         6, 855         181, 195         0. 037832         19, 747         747         68. 00           69. 00         D6900         ELECTROCARDI OLOGY         35, 942         3, 924, 838         0. 009158         201, 017         1, 841         69. 00           71. 00         O7100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         2, 380         137, 764         0. 017276         0         0         72. 00  |   | 1             |                | 1        |               |                 |         |
| 58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI )         46, 422         1, 162, 413         0. 039936         20, 130         804         58. 00           60. 00         06000         LABORATORY         179, 671         6, 897, 448         0. 026049         384, 402         10, 013         60. 00           66. 00         06600         PHYSI CAL THERAPY         143, 919         1, 429, 915         0. 100649         113, 127         11, 386         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         13, 530         307, 097         0. 044058         47, 570         2, 096         67. 00           68. 00         06800         SPEECH PATHOLOGY         6, 855         181, 195         0. 037832         19, 747         747         68. 00           69. 00         06900         ELECTROCARDI OLOGY         35, 942         3, 924, 838         0. 009158         201, 017         1, 841         69. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         28, 792         461, 519         0. 062385         4, 839         302         71. 00           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS         2, 380         137, 764         0. 017276         0         0         0 </td <td>• • • • • • • • • • • • • • • • • • •</td> <td>1</td> <td></td> <td>1</td> <td></td> <td></td> <td></td>  | • • • • • • • • • • • • • • • • • • •               | 1             |                | 1        |               |                 |         |
| 60. 00   |   | 57, 483       | 4, 536, 850    |          |               | 656             |         |
| 66. 00   06600   PHYSI CAL THERAPY   143, 919   1, 429, 915   0. 100649   113, 127   11, 386   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   13, 530   307, 097   0. 044058   47, 570   2, 096   67. 00   68. 00   06800   SPEECH PATHOLOGY   6, 855   181, 195   0. 037832   19, 747   747   68. 00   69. 00   06900   ELECTROCARDI OLOGY   35, 942   3, 924, 838   0. 009158   201, 017   1, 841   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   28, 792   461, 519   0. 062385   4, 839   302   71. 00   72. 00   1MPL. DEV. CHARGED TO PATI ENTS   2, 380   137, 764   0. 017276   0   0   0   72. 00   73. 01   07300   DRUGS CHARGED TO PATI ENTS   37, 386   6, 766, 342   0. 005525   875, 289   4, 836   73. 00   73. 01   07301   0NCOLOGY DRUGS   108, 697   3, 832, 777   0. 028360   0   0   73. 01   03020   CARDI OPULMONARY   103, 650   874, 284   0. 118554   196, 228   23, 264   76. 00   007000   CLI NI C   0000000   000000   000000   00000000  |   | 46, 422       | 1, 162, 413    |          |               | 804             | 58. 00  |
| 67. 00   |   | 179, 671      | 6, 897, 448    | 0. 02604 | 9 384, 402    | 10, 013         | 60.00   |
| 68. 00   06800   SPEECH PATHOLOGY   6, 855   181, 195   0. 037832   19, 747   747   68. 00   69. 00   06900   ELECTROCARDI OLOGY   35, 942   3, 924, 838   0. 009158   201, 017   1, 841   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   28, 792   461, 519   0. 062385   4, 839   302   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   2, 380   137, 764   0. 017276   0   0   0   72. 00   07300   DRUGS CHARGED TO PATI ENTS   37, 386   6, 766, 342   0. 005525   875, 289   4, 836   73. 00   07301   ONCOLOGY DRUGS   108, 697   3, 832, 777   0. 028360   0   0   0   73. 01   07301   ONCOLOGY DRUGS   103, 650   874, 284   0. 118554   196, 228   23, 264   76. 00   00000   CLI NI C   000000   CLI NI C   0000000   000000   0000000000   000000   |   | 143, 919      | 1, 429, 915    | 0. 10064 | 9 113, 127    | 11, 386         | 66. 00  |
| 69. 00   | 67. 00 06700 OCCUPATI ONAL THERAPY                  | 13, 530       | 307, 097       | 0.04405  | 47, 570       | 2, 096          | 67. 00  |
| 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   28, 792   461, 519   0.062385   4, 839   302   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 01   73. 00   73. 01   73. 0 | 68.00 06800 SPEECH PATHOLOGY                        | 6, 855        | 181, 195       | 0. 03783 | 19, 747       | 747             | 68. 00  |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   2, 380   137, 764   0. 017276   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   37, 386   6, 766, 342   0. 005525   875, 289   4, 836   73. 00   73. 01   07301   0NCOLOGY DRUGS   108, 697   3, 832, 777   0. 028360   0   0   0   73. 01   03020   CARDI OPULMONARY   103, 650   874, 284   0. 118554   196, 228   23, 264   76. 00   00000   CLI NI C   000000   CLI NI C   000000   CLI NI C   000000   CLI NI C   000000   CLI NI C   0000000   000000   0000000   00000000   | 69. 00 06900 ELECTROCARDI OLOGY                     | 35, 942       | 3, 924, 838    | 0. 00915 | 201, 017      | 1, 841          | 69. 00  |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   37, 386   6, 766, 342   0.005525   875, 289   4, 836   73. 00   73. 01   07301   0NCOLOGY DRUGS   108, 697   3, 832, 777   0.028360   0   0   73. 01   03020   CARDI OPULMONARY   103, 650   874, 284   0.118554   196, 228   23, 264   76. 00   00000   CLI NI C   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   090000   09000   09000   090000   09000   090000   090000   090000   090000   0900000   09000000   09000000   09000000   0900000000   | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS    | 28, 792       | 461, 519       | 0. 06238 | 4, 839        | 302             | 71.00   |
| 73. 01   07301   0NCOLOGY DRUGS   108, 697   3, 832, 777   0. 028360   0   0   0   73. 01   76. 00   03020   CARDI OPULMONARY   103, 650   874, 284   0. 118554   196, 228   23, 264   76. 00   0UTPATI ENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C   101, 625   983, 710   0. 103308   0   0   0   791. 00   09100   EMERGENCY   524, 520   17, 034, 262   0. 030792   28, 859   889   91. 00   792. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   311, 901   4, 590, 559   0. 067944   1, 092   74   92. 00   792. 01   09201   0BSERVATI ON BEDS (DI STI NCT PART)   0   0   0. 000000   0   0   92. 01  | 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 2, 380        | 137, 764       | 0. 01727 | '6 0          | 0               | 72.00   |
| 73. 01   07301   0NCOLOGY DRUGS   108,697   3,832,777   0.028360   0   0   73.01   76. 00   03020   CARDI OPULMONARY   103,650   874,284   0.118554   196,228   23,264   76. 00   0UTPATI ENT SERVI CE COST CENTERS   983,710   0.103308   0   0   0   791. 00   09100   EMERGENCY   524,520   17,034,262   0.030792   28,859   889   91.00   792. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   311,901   4,590,559   0.067944   1,092   74   92.00   792. 01   09201   0BSERVATI ON BEDS (DI STI NCT PART)   0   0   0.000000   0   0   92.01   | 73.00 07300 DRUGS CHARGED TO PATIENTS               | 37, 386       | 6, 766, 342    | 0.00552  | 875, 289      | 4, 836          | 73.00   |
| 76. 00 03020 CARDI OPULMONARY 103,650 874,284 0. 118554 196,228 23,264 76. 00 OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 101,625 983,710 0. 103308 0 0 0 90. 00 91. 00 09100 EMERGENCY 524,520 17,034,262 0. 030792 28,859 889 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 311,901 4,590,559 0. 067944 1,092 74 92. 00 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0. 0000000 0 0 92. 01  | 73. 01 07301 ONCOLOGY DRUGS                         | 108, 697      |                |          |               |                 | 73. 01  |
| OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         101, 625         983, 710         0. 103308         0         0         90. 00           91. 00         09100 EMERGENCY         524, 520         17, 034, 262         0. 030792         28, 859         889         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DISTINCT PART)         311, 901         4, 590, 559         0. 067944         1, 092         74         92. 00           92. 01         09201 OBSERVATI ON BEDS (DISTINCT PART)         0         0         0. 0000000         0         0         92. 01   |   | 1             |                | 1        |               | 23. 264         | 76, 00  |
| 90. 00   09000   CLI NI C   101, 625   983, 710   0. 103308   0   0   90. 00   91. 00   09100   EMERGENCY   524, 520   17, 034, 262   0. 030792   28, 859   889   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   311, 901   4, 590, 559   0. 067944   1, 092   74   92. 00   92. 01   09201   0BSERVATI ON BEDS (DI STI NCT PART)   0   0   0. 0000000   0   0   92. 01   |   |               |                |          |               |                 |         |
| 91. 00   09100   EMERGENCY   524,520   17,034,262   0.030792   28,859   889   91.00   92.00   09200   09500    |   | 101, 625      | 983. 710       | 0. 10330 | 0.8           | 0               | 90.00   |
| 92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   311,901   4,590,559   0.067944   1,092   74   92.00   92.01   09201   0BSERVATION BEDS (DISTINCT PART)   0   0.000000   0   0   92.01  | 91. 00 09100 EMERGENCY                              | 1             |                | 0. 03079 | 28, 859       | 889             | 91.00   |
| 92.01   09201   0BSERVATION BEDS (DISTINCT PART)   0   0.000000   0   0   92.01  |   |               |                | 1        |               |                 |         |
|  |   | 0.1,751       | 1, 0,0,00      | 1        |               |                 |         |
|  | , , ,   | 2.704 280     | 68, 407, 862   | 1        |               | ·               | 1       |
|  |   |               | 1 22, 107, 002 | 1        |               | 30,             | 1       |

| Health Financial Systems              | IU HEALTH WHITE              | HOSPI TAL             | In Lie          | u of Form CMS-2552-10            |
|---------------------------------------|------------------------------|-----------------------|-----------------|----------------------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS | Provider CCN: 15-1312 | Peri od:        | Worksheet D                      |
| THROUGH COSTS                         |                              |                       | From 01/01/2017 | Part IV<br>  Date/Time Prepared: |

|        |  |               |                |                | 0 12/31/2017  | 5/25/2018 5: 2 |         |
|--------|--|---------------|----------------|----------------|---------------|----------------|---------|
|        |  |               | Title          | XVIII          | Hospi tal     | Cost           |         |
|        | Cost Center Description                    | Non Physician | Nursing School | Nursing School | Allied Health | Allied Health  |         |
|        |  |               | Post-Stepdown  |                | Post-Stepdown |                |         |
|        |  | Cost          | Adjustments    |                | Adjustments   |                |         |
|        |  | 1. 00         | 2A             | 2.00           | 3A            | 3. 00          |         |
|        | ANCILLARY SERVICE COST CENTERS             |               |                |                |               |                |         |
|        | 05000 OPERATING ROOM                       | 0             | 0              | ) (            | 0             | 0              | 50.00   |
|        | 05200 DELIVERY ROOM & LABOR ROOM           | 0             | 0              | ) (            | 0             | 0              | 52. 00  |
|        | 05400 RADI OLOGY-DI AGNOSTI C              | 0             | 0              | ) (            | 0             | 0              | 54.00   |
|        | 05500 RADI OLOGY-THERAPEUTI C              | 0             | 0              | ) (            | 0             | 0              | 55. 00  |
|        | 03630 ULTRA SOUND                          | 0             | 0              | ) (            | 0             | 0              | 56. 00  |
|        | 05700 CT SCAN                              | 0             | 0              | ) (            | 0             | 0              | 57. 00  |
|        | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0             | 0              | ) (            | 0             | 0              | 58. 00  |
|        | 06000 LABORATORY                           | 0             | 0              | ) (            | 0             | 0              | 60.00   |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 0             | 0              | ) (            | 0             | 0              | 66. 00  |
|        | 06700 OCCUPATI ONAL THERAPY                | 0             | 0              | ) (            | 0             | 0              | 67. 00  |
|        | 06800 SPEECH PATHOLOGY                     | 0             | 0              | ) (            | 0             | 0              | 68. 00  |
|        | 06900 ELECTROCARDI OLOGY                   | 0             | 0              | ) (            | 0             | 0              | 69. 00  |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0             | 0              | ) (            | 0             | 0              | 71. 00  |
|        | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0             | 0              | ) (            | 0             | 0              | 72. 00  |
|        | 07300 DRUGS CHARGED TO PATIENTS            | 0             | 0              | ) (            | 0             | 0              | 73. 00  |
|        | 07301 ONCOLOGY DRUGS                       | 0             | 0              | ) (            | 0             | 0              | 73. 01  |
| 76. 00 | 03020 CARDI OPULMONARY                     | 0             | 0              | ) (            | 0             | 0              | 76. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |               |                |                |               |                |         |
|        | 09000 CLI NI C                             | 0             | 0              | ) (            | 0             | 0              | 90.00   |
|        | 09100 EMERGENCY                            | 0             | 0              | ) (            | 0             | 0              | 91. 00  |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0             |                |                | )             | 0              | 92. 00  |
|        | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0             | 0              | ) (            | 0             | 0              | 92. 01  |
| 200.00 | Total (lines 50 through 199)               | 0             | 0              | )  (           | )  0          | 0              | 200. 00 |

| Health Financial Systems             | IU HEALTH WHITE                | HOSPI TAL             | In Lie   | u of Form CMS-2552-10 |
|--------------------------------------|--------------------------------|-----------------------|----------|-----------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIEN | F ANCILLARY SERVICE OTHER PASS | Provider CCN: 15-1312 | Peri od: | Worksheet D           |

From 01/01/2017 Part IV
To 12/31/2017 Date/Time Prepared: THROUGH COSTS 5/25/2018 5:20 pm Title XVIII Hospi tal Cost All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total (from Wkst. C, to Charges Medi cal (sum of col 1 Outpati ent Education Cost through col. Cost (sum of Part I, col. (col. 5 ÷ col col. 2, 3 and 8) 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 7, 295, 188 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.00000052.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 5, 245, 266 0.000000 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 942, 633 0.000000 55.00 OI 03630 ULTRA SOUND 56.00 1, 803, 802 0.000000 56.00 57.00 05700 CT SCAN 0 0 4, 536, 850 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 162, 413 0.000000 58.00 06000 LABORATORY 0 0 6, 897, 448 0.000000 60 00 60 00 06600 PHYSI CAL THERAPY 1, 429, 915 0 0.000000 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 307, 097 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 181, 195 68.00 06900 ELECTROCARDI OLOGY 3, 924, 838 0.000000 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 461, 519 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 137, 764 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 73 00 0 6, 766, 342 73 00 0 73. 01 07301 ONCOLOGY DRUGS 0 3, 832, 777 0.000000 73.01 76.00 03020 CARDI OPULMONARY 0 874, 284 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 0 0 0 0 0 983, 710 0.000000 90 00 09000 CLI NI C 0 0 91. 00 | 09100 | EMERGENCY 17, 034, 262 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 4, 590, 559 0.000000 92.00 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0.000000 92.01

68, 407, 862

200.00

200.00

Total (lines 50 through 199)

| Health Financial Sy              | rstems                  |              | IU HEALTH WH                | ΙΤΕ | HOSPI TAL            |                      | In Lie                | u of Form CMS-2   | 2552-10 |
|----------------------------------|-------------------------|--------------|-----------------------------|-----|----------------------|----------------------|-----------------------|---|---------|
| APPORTIONMENT OF INTHROUGH COSTS | NPATI ENT/OUTPATI ENT A | ANCILLARY SE | ERVICE OTHER PAS            | SS  | Provider CC          | CN: 15-1312          |                       | Worksheet D<br>Part IV<br>Date/Time Pre<br>5/25/2018 5:20 |         |
| •                                |                         |              |                             |     | Title                | XVIII                | Hospi tal             | Cost  |         |
| Cost Ce                          | enter Description       |              | Outpatient<br>Ratio of Cost |     | Inpatient<br>Program | Inpatient<br>Program | Outpatient<br>Program | Outpati ent<br>Program                                    |         |

|                          |                               |                |             |               |             | 5/25/2018 5: 2 |         |
|--------------------------|-------------------------------|----------------|-------------|---------------|-------------|----------------|---------|
|                          |                               |                | Title       | XVIII         | Hospi tal   | Cost           |         |
| Cost Ce                  | nter Description              | Outpati ent    | I npati ent | I npati ent   | Outpati ent | Outpati ent    |         |
|                          |                               | Ratio of Cost  | Program     | Program       | Program     | Program        |         |
|                          |                               | to Charges     | Charges     | Pass-Through  |             | Pass-Through   |         |
|                          |                               | (col. 6 ÷ col. |             | Costs (col. 8 | 3           | Costs (col. 9  |         |
|                          |                               | 7)             |             | x col. 10)    |             | x col. 12)     |         |
|                          |                               | 9. 00          | 10. 00      | 11. 00        | 12. 00      | 13. 00         |         |
|                          | RVICE COST CENTERS            |                |             | •             |             | ,              |         |
| 50. 00   05000 OPERATI   |                               | 0. 000000      | 19, 566     |               | 0           | 0              | 50. 00  |
|                          | Y ROOM & LABOR ROOM           | 0. 000000      | 0           |               | 0           | 0              | 52. 00  |
|                          | GY-DI AGNOSTI C               | 0. 000000      | 27, 311     |               | 0           | 0              | 54. 00  |
|                          | GY-THERAPEUTI C               | 0. 000000      | 0           |               | 0           | 0              | 55. 00  |
| 56. 00  03630   ULTRA S  |                               | 0. 000000      | 44, 835     |               | 0           | 0              | 56. 00  |
| 57.00  05700 CT SCAN     |                               | 0. 000000      | 51, 764     |               | 0           | 0              | 57. 00  |
| 58. 00   05800   MAGNETI | C RESONANCE IMAGING (MRI)     | 0. 000000      | 20, 130     |               | 0           | 0              | 58. 00  |
| 60. 00   06000   LABORAT | ORY                           | 0. 000000      | 384, 402    |               | 0           | 0              | 60.00   |
| 66. 00   06600 PHYSI CA  | L THERAPY                     | 0. 000000      | 113, 127    |               | 0           | 0              | 66. 00  |
| 67. 00   06700   0CCUPAT |                               | 0. 000000      | 47, 570     |               | 0           | 0              | 67. 00  |
| 68. 00   06800   SPEECH  | PATHOLOGY                     | 0. 000000      | 19, 747     |               | 0           | 0              | 68. 00  |
| 69. 00   06900   ELECTRO | CARDI OLOGY                   | 0. 000000      | 201, 017    |               | 0           | 0              | 69. 00  |
| 71. 00 07100 MEDI CAL    | SUPPLIES CHARGED TO PATIENTS  | 0. 000000      | 4, 839      |               | 0           | 0              | 71. 00  |
| 72.00 07200 I MPL. D     | EV. CHARGED TO PATIENTS       | 0. 000000      | 0           |               | 0           | 0              | 72. 00  |
| 73. 00 07300 DRUGS C     | HARGED TO PATIENTS            | 0. 000000      | 875, 289    |               | 0           | 0              | 73. 00  |
| 73. 01 07301 ONCOLOG     | Y DRUGS                       | 0. 000000      | 0           |               | 0           | 0              | 73. 01  |
| 76. 00 03020 CARDI OF    | ULMONARY                      | 0. 000000      | 196, 228    |               | 0           | 0              | 76. 00  |
| OUTPATIENT SE            | RVICE COST CENTERS            |                |             |               |             |                |         |
| 90. 00 09000 CLI NI C    |                               | 0. 000000      | 0           |               | 0           | 0              | 90.00   |
| 91. 00 09100 EMERGEN     | CY                            | 0. 000000      | 28, 859     |               | 0           | 0              | 91.00   |
| 92. 00 09200 OBSERVA     | TION BEDS (NON-DISTINCT PART) | 0. 000000      | 1, 092      |               | 0 0         | 0              | 92.00   |
| 92. 01 09201 OBSERVA     | TION BEDS (DISTINCT PART)     | 0. 000000      | 0           |               | 0 0         | 0              | 92. 01  |
| 200.00 Total (           | lines 50 through 199)         |                | 2, 035, 776 |               | 0 0         | 0              | 200. 00 |

| Health Fin  | ancial Systems                             | IU HEALTH WHI  | TE HOSPITAL   |               | In Lie         | eu of Form CMS-2 | 2552-10 |
|-------------|--|----------------|---------------|---------------|----------------|------------------|---------|
| APPORTI ONN | MENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST   | Provi der Co  | CN: 15-1312 F | Peri od:       | Worksheet D      |         |
|             |  |                |               | F             | rom 01/01/2017 | Part V           |         |
|             |  |                |               | 7             | To 12/31/2017  | Date/Time Pre    |         |
|             |  |                |               |               |                | 5/25/2018 5: 2   | 0 pm    |
|             |  |                | Title         | XVIII         | Hospi tal      | Cost             |         |
|             |  |                |               | Charges       |                | Costs            |         |
|             | Cost Center Description                    | Cost to Charge |               |               | Cost           | PPS Services     |         |
|             |  |                | Services (see | Reimbursed    | Rei mbursed    | (see inst.)      |         |
|             |  | Worksheet C,   | inst.)        | Servi ces     | Services Not   |                  |         |
|             |  | Part I, col. 9 |               | Subject To    | Subject To     |                  |         |
|             |  |                |               | Ded. & Coins. | Ded. & Coins.  |                  |         |
|             |  |                |               | (see inst.)   | (see inst.)    |                  |         |
|             |  | 1.00           | 2.00          | 3. 00         | 4. 00          | 5. 00            |         |
| ANCI        | ILLARY SERVICE COST CENTERS                |                |               |               |                |                  |         |
| 50.00 0500  | OO OPERATING ROOM                          | 0. 355296      | 0             | 2, 642, 447   | 7 0            | 0                | 50. 00  |
| 52.00 0520  | OO DELIVERY ROOM & LABOR ROOM              | 0. 000000      | 0             | (             | o              | 0                | 52.00   |
| 54. 00 0540 | OO RADI OLOGY-DI AGNOSTI C                 | 0. 206563      | 0             | 1, 547, 042   | 0              | 0                | 54.00   |
|             | OO RADI OLOGY-THERAPEUTI C                 | 0. 216198      | l .           | 417, 759      |                | 0                | 55.00   |
| 56, 00 036  | 30 ULTRA SOUND                             | 0. 132095      | 0             | 733, 263      |                | 0                | 56. 00  |
|             | OO CT SCAN                                 | 0. 134696      | l o           | 1, 604, 372   |                | 0                | 57. 00  |
|             | 00 MAGNETIC RESONANCE IMAGING (MRI)        | 0. 233617      | 0             | 448, 950      |                | 0                | 58. 00  |
|             | 00 LABORATORY                              | 0. 272960      | 0             | 2, 468, 88    |                | 1                | 60.00   |
|             | 00 PHYSI CAL THERAPY                       | 0. 505847      | 0             | 414, 103      |                | 1                | 66.00   |
|             | OO OCCUPATIONAL THERAPY                    | 0. 628212      | 0             | 48, 419       |                | 1                | 67.00   |
|             | l .  |                | 0             |               |                | 1                |         |
|             | 00 SPEECH PATHOLOGY                        | 0. 686956      | 0             | 20, 328       |                | 0                | 68. 00  |
|             | 00 ELECTROCARDI OLOGY                      | 0. 080824      |               | 1, 497, 424   |                | 0                | 69. 00  |
|             | 00 MEDICAL SUPPLIES CHARGED TO PATIENTS    | 0. 348774      | 0             | 101, 935      |                | 0                | 71. 00  |
|             | 00 IMPL. DEV. CHARGED TO PATIENTS          | 0. 130172      | 0             | 28, 205       |                | 0                | 72. 00  |
|             | 00 DRUGS CHARGED TO PATIENTS               | 0. 119557      | l e           | 2, 259, 338   |                | 0                | 73. 00  |
|             | 01 ONCOLOGY DRUGS                          | 0. 613644      |               | 2, 740, 888   |                | 0                | 73. 01  |
|             | 20 CARDI OPULMONARY                        | 0. 874733      | 0             | 206, 429      | 9 0            | 0                | 76. 00  |
|             | PATIENT SERVICE COST CENTERS               |                |               |               |                |                  |         |
| 90.00 0900  | OO CLI NI C                                | 0. 438729      | 0             | 519, 824      |                |                  | 90. 00  |
| 91.00 0910  | OO EMERGENCY                               | 0. 268232      | 0             | 4, 962, 483   | 1, 596         | 0                | 91.00   |
| 92.00 0920  | OO OBSERVATION BEDS (NON-DISTINCT PART)    | 0. 366641      | 0             | 2, 769, 046   | 0              | 0                | 92.00   |
| 92. 01 0920 | 01 OBSERVATION BEDS (DISTINCT PART)        | 0. 000000      | 0             | (             | o              | 0                | 92. 01  |
| 200.00      | Subtotal (see instructions)                |                | 0             | 25, 431, 136  | 4, 695         | 0                | 200. 00 |
| 201. 00     | Less PBP Clinic Lab. Services-Program      |                |               | (             | 0              |                  | 201. 00 |
|             | Only Charges                               |                |               | `             |                |                  |         |
| 202. 00     | Net Charges (line 200 - line 201)          |                | 0             | 25, 431, 136  | 4, 695         | 0                | 202. 00 |
| _02.00      | [ 200 (a 200a 201)                         | I              |               | 20, 101, 100  | ., 0,0         |                  |         |

|        |  |             |               |       | To 12/31/2017 | Date/Time Pre<br>  5/25/2018 5:2 |          |
|--------|--|-------------|---------------|-------|---------------|----------------------------------|----------|
|        |  |             | Title         | XVIII | Hospi tal     | Cost                             | <u> </u> |
|        |  | Cos         | ts            |       |               |                                  |          |
|        | Cost Center Description                    | Cost        | Cost          |       |               |                                  |          |
|        |  | Rei mbursed | Rei mbursed   |       |               |                                  |          |
|        |  | Servi ces   | Services Not  |       |               |                                  |          |
|        |  | Subject To  | Subject To    |       |               |                                  |          |
|        |  |             | Ded. & Coins. |       |               |                                  |          |
|        |  | (see inst.) | (see inst.)   |       |               |                                  |          |
|        |  | 6. 00       | 7. 00         |       |               |                                  |          |
|        | ANCILLARY SERVICE COST CENTERS             |             |               |       |               |                                  |          |
| 50.00  | 05000 OPERATI NG ROOM                      | 938, 851    | 0             |       |               |                                  | 50. 00   |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM           | 0           | 0             |       |               |                                  | 52. 00   |
| 54. 00 | 05400  RADI OLOGY-DI AGNOSTI C             | 319, 562    | 0             |       |               |                                  | 54. 00   |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C              | 90, 319     | 0             |       |               |                                  | 55. 00   |
| 56. 00 | 03630 ULTRA SOUND                          | 96, 860     | 0             |       |               |                                  | 56. 00   |
| 57.00  | 05700 CT SCAN                              | 216, 102    | 0             |       |               |                                  | 57. 00   |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 104, 882    | 0             |       |               |                                  | 58. 00   |
| 60.00  | 06000 LABORATORY                           | 673, 906    | 0             |       |               |                                  | 60.00    |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 209, 473    | 0             |       |               |                                  | 66. 00   |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 30, 417     | 0             |       |               |                                  | 67. 00   |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 13, 964     | 0             |       |               |                                  | 68. 00   |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 121, 028    | 0             |       |               |                                  | 69. 00   |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 35, 552     | 0             |       |               |                                  | 71. 00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 3, 672      | 0             |       |               |                                  | 72. 00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 270, 120    | 371           |       |               |                                  | 73. 00   |
| 73. 01 | 07301 ONCOLOGY DRUGS                       | 1, 681, 929 | 0             |       |               |                                  | 73. 01   |
| 76.00  | 03020 CARDI OPULMONARY                     | 180, 570    | 0             |       |               |                                  | 76. 00   |
|        | OUTPATIENT SERVICE COST CENTERS            |             |               |       |               |                                  |          |
| 90.00  | 09000 CLI NI C                             | 228, 062    | 0             |       |               |                                  | 90.00    |
| 91.00  | 09100 EMERGENCY                            | 1, 331, 097 | 428           |       |               |                                  | 91.00    |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 015, 246 | 0             |       |               |                                  | 92.00    |
| 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0           | 0             |       |               |                                  | 92. 01   |
| 200.00 | Subtotal (see instructions)                | 7, 561, 612 | 799           |       |               |                                  | 200. 00  |
| 201.00 | Less PBP Clinic Lab. Services-Program      | 0           |               |       |               |                                  | 201. 00  |
|        | Only Charges                               |             |               |       |               |                                  |          |
| 202.00 | Net Charges (line 200 - line 201)          | 7, 561, 612 | 799           |       |               |                                  | 202. 00  |

|             |   |                | oomponone.     | 0014. 10 2012 | 0 12/01/201/    | 5/25/2018 5: 2 |         |
|-------------|---|----------------|----------------|---------------|-----------------|----------------|---------|
|             |   |                | Titl∈          | XVIII Sv      | ving Beds - SNF | Cost           |         |
|             |   |                |                | Charges       |                 | Costs          |         |
|             | Cost Center Description                 | Cost to Charge | PPS Reimbursed | Cost          | Cost            | PPS Services   |         |
|             |   | Ratio From     | Services (see  | Rei mbursed   | Rei mbursed     | (see inst.)    |         |
|             |   | Worksheet C,   | inst.)         | Servi ces     | Services Not    |                |         |
|             |   | Part I, col. 9 |                | Subject To    | Subject To      |                |         |
|             |   |                |                | Ded. & Coins. | Ded. & Coins.   |                |         |
|             |   |                |                | (see inst.)   | (see inst.)     |                |         |
|             |   | 1.00           | 2. 00          | 3. 00         | 4. 00           | 5. 00          |         |
|             | LLARY SERVICE COST CENTERS              |                |                |               |                 |                |         |
|             | OO OPERATING ROOM                       | 0. 355296      | 0              | 0             | 0               | 0              | 50. 00  |
|             | DO DELIVERY ROOM & LABOR ROOM           | 0. 000000      | 0              | 0             | 0               | 0              | 52. 00  |
| 54.00 0540  | DO RADI OLOGY-DI AGNOSTI C              | 0. 206563      | 0              | 0             | 0               | 0              | 54.00   |
| 55. 00 0550 | OO RADI OLOGY-THERAPEUTI C              | 0. 216198      | 0              | 0             | 0               | 0              | 55. 00  |
| 56. 00 0363 | 30 ULTRA SOUND                          | 0. 132095      | 0              | 0             | 0               | 0              | 56. 00  |
| 57. 00 0570 | OO CT SCAN                              | 0. 134696      | 0              | 0             | 0               | 0              | 57. 00  |
| 58. 00 0580 | OO MAGNETIC RESONANCE IMAGING (MRI)     | 0. 233617      | 0              | 0             | 0               | 0              | 58. 00  |
| 60.00 0600  | DO LABORATORY                           | 0. 272960      | 0              | 0             | 0               | 0              | 60.00   |
| 66. 00 0660 | DO PHYSI CAL THERAPY                    | 0. 505847      | 0              | 0             | 0               | 0              | 66. 00  |
| 67. 00 0670 | OCCUPATIONAL THERAPY                    | 0. 628212      | 0              | 0             | 0               | 0              | 67. 00  |
| 68. 00 0680 | OO SPEECH PATHOLOGY                     | 0. 686956      | 0              | 0             | 0               | 0              | 68. 00  |
| 69. 00 0690 | DO ELECTROCARDI OLOGY                   | 0. 080824      | 0              | 0             | 0               | 0              | 69. 00  |
| 71. 00 0710 | MEDICAL SUPPLIES CHARGED TO PATIENTS    | 0. 348774      | 0              | 0             | 0               | 0              | 71. 00  |
| 72. 00 0720 | OO IMPL. DEV. CHARGED TO PATIENTS       | 0. 130172      | 0              | 0             | 0               | 0              | 72. 00  |
| 73. 00 0730 | DO DRUGS CHARGED TO PATIENTS            | 0. 119557      | 0              | 0             | 0               | 0              | 73. 00  |
| 73. 01 0730 | O1 ONCOLOGY DRUGS                       | 0. 613644      | 0              | 0             | 0               | 0              | 73. 01  |
| 76. 00 0302 | 20 CARDI OPULMONARY                     | 0. 874733      | 0              | 0             | 0               | 0              | 76. 00  |
| OUTF        | PATIENT SERVICE COST CENTERS            |                |                |               |                 |                | 1       |
| 90.00 0900  | DO CLI NI C                             | 0. 438729      | 0              | 0             | 0               | 0              | 90. 00  |
| 91. 00 0910 | DO EMERGENCY                            | 0. 268232      | 0              | 0             | 0               | 0              | 91. 00  |
| 92. 00 0920 | OO OBSERVATION BEDS (NON-DISTINCT PART) | 0. 366641      | 0              | 0             | 0               | 0              | 92.00   |
| 92. 01 0920 | O1 OBSERVATION BEDS (DISTINCT PART)     | 0. 000000      | 0              | 0             | 0               | 0              | 92. 01  |
| 200.00      | Subtotal (see instructions)             |                | 0              | 0             | 0               | 0              | 200. 00 |
| 201.00      | Less PBP Clinic Lab. Services-Program   |                |                | 0             | 0               |                | 201. 00 |
|             | Only Charges                            |                |                |               |                 |                |         |
| 202. 00     | Net Charges (line 200 - line 201)       |                | 0              | 0             | 0               | 0              | 202. 00 |

Health Financial Systems IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1312 From 01/01/2017 To 12/31/2017 To 12/31/2017 To 12/31/2017 To 12/31/2017 Systems Prepared: 5/25/2018 5:20 pm

|  |               | Component     | CCN: 15-Z312 | То     | 12/31/2 | 2017 | Date/Time Prep.<br>5/25/2018 5:20 |         |
|--|---------------|---------------|--------------|--------|---------|------|-----------------------------------|---------|
|  |               | Ti tl e       | e XVIII      | Swi no | Beds -  | SNF  | Cost                              |         |
|  | Cos           | sts           |              |        |         |      |                                   |         |
| Cost Center Description                          | Cost          | Cost          |              |        |         |      |                                   |         |
|  | Rei mbursed   | Rei mbursed   |              |        |         |      |                                   |         |
|  | Servi ces     | Services Not  |              |        |         |      |                                   |         |
|  | Subject To    | Subject To    |              |        |         |      |                                   |         |
|  | Ded. & Coins. | Ded. & Coins. |              |        |         |      |                                   |         |
|  | (see inst.)   | (see inst.)   |              |        |         |      |                                   |         |
|  | 6. 00         | 7. 00         |              |        |         |      |                                   |         |
| ANCILLARY SERVICE COST CENTERS                   |               |               |              |        |         |      |                                   |         |
| 50.00   05000   OPERATING ROOM                   | 0             | C             |              |        |         |      | 1                                 | 50.00   |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM       | 0             | C             | )            |        |         |      |                                   | 52.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0             | C             | )            |        |         |      |                                   | 54.00   |
| 55. 00   05500 RADI OLOGY-THERAPEUTI C           | 0             | C             | )            |        |         |      |                                   | 55.00   |
| 56. 00   03630   ULTRA SOUND                     | 0             | C             | )            |        |         |      |                                   | 56.00   |
| 57.00  05700   CT SCAN                           | 0             | C             | )            |        |         |      |                                   | 57.00   |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0             | C             | )            |        |         |      |                                   | 58.00   |
| 60. 00   06000   LABORATORY                      | 0             | C             | )            |        |         |      |                                   | 60.00   |
| 66. 00   06600   PHYSI CAL THERAPY               | 0             | C             | )            |        |         |      |                                   | 66.00   |
| 67. 00   06700   OCCUPATI ONAL THERAPY           | 0             | C             | )            |        |         |      |                                   | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                     | 0             | C             | )            |        |         |      |                                   | 68.00   |
| 69. 00   06900   ELECTROCARDI OLOGY              | 0             | C             | )            |        |         |      |                                   | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0             | C             | )            |        |         |      |                                   | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0             | C             | )            |        |         |      |                                   | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0             | C             | )            |        |         |      |                                   | 73.00   |
| 73. 01   07301   0NC0L0GY DRUGS                  | 0             | C             | )            |        |         |      |                                   | 73. 01  |
| 76. 00 03020 CARDI OPULMONARY                    | 0             | C             | )            |        |         |      |                                   | 76.00   |
| OUTPATIENT SERVICE COST CENTERS                  |               |               |              |        |         |      |                                   |         |
| 90. 00   09000   CLI NI C                        | 0             | C             | )            |        |         |      |                                   | 90.00   |
| 91. 00   09100   EMERGENCY                       | 0             | C             | )            |        |         |      |                                   | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0             | C             | )            |        |         |      |                                   | 92.00   |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART)     | 0             | C             | )            |        |         |      |                                   | 92. 01  |
| 200.00 Subtotal (see instructions)               | 0             | C             | )            |        |         |      | 2                                 | 200.00  |
| 201.00 Less PBP Clinic Lab. Services-Program     | 0             |               |              |        |         |      | 2                                 | 201. 00 |
| Only Charges                                     |               |               |              |        |         |      |                                   |         |
| 202.00   Net Charges (line 200 - line 201)       | 0             | (             | )            |        |         |      | 2                                 | 202. 00 |
|  |               |               |              |        |         |      |                                   |         |

| Heal th | Financial Systems                              | IU HEALTH WHI  | TE HOSPITAL    |               | In Lie                                      | eu of Form CMS-2 | 2552-10 |
|---------|--|----------------|----------------|---------------|---|------------------|---------|
| APPORT  | TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST | Provi der C    |               | Period:<br>From 01/01/2017<br>To 12/31/2017 |                  |         |
|         |  |                | Ti tl          | e XIX         | Hospi tal                                   | Cost             |         |
|         |  |                |                | Charges       |   | Costs            |         |
|         | Cost Center Description                        | Cost to Charge | PPS Reimbursed | Cost          | Cost  | PPS Services     |         |
|         |  | Ratio From     | Services (see  | Reimbursed    | Rei mbursed                                 | (see inst.)      |         |
|         |  | Worksheet C,   | inst.)         | Servi ces     | Services Not                                |                  |         |
|         |  | Part I, col. 9 |                | Subject To    | Subject To                                  |                  |         |
|         |  |                |                | Ded. & Coins. |   |                  |         |
|         |  |                |                | (see inst.)   | (see inst.)                                 |                  |         |
|         |  | 1.00           | 2. 00          | 3. 00         | 4. 00                                       | 5. 00            |         |
|         | ANCILLARY SERVICE COST CENTERS                 |                |                |               | _   |                  |         |
| 50.00   | 05000 OPERATI NG ROOM                          | 0. 355296      | 0              | 1             | 0   | 0                |         |
|         | 05200 DELIVERY ROOM & LABOR ROOM               | 0. 000000      | 0              |               | 0   | 0                |         |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C                  | 0. 206563      | 0              | )             | 0   | 0                | 54.00   |
| 55. 00  | 05500 RADI OLOGY-THERAPEUTI C                  | 0. 216198      | 0              | )             | 0   | 0                | 55. 00  |
| 56.00   | 03630 ULTRA SOUND                              | 0. 132095      | 0              | )             | 0   | 0                | 56. 00  |
| 57.00   | 05700  CT SCAN                                 | 0. 134696      | 0              |               | 0 0   | 0                | 57.00   |
| 58.00   | 05800 MAGNETIC RESONANCE IMAGING (MRI)         | 0. 233617      | 0              |               | 0 0   | 0                | 58. 00  |
| 60.00   | 06000 LABORATORY                               | 0. 272960      | 0              |               | 0 0   | 0                |         |
| 66.00   | 06600 PHYSI CAL THERAPY                        | 0. 505847      | 0              |               | 0 0   | 0                | 66. 00  |
| 67.00   | 06700 OCCUPATI ONAL THERAPY                    | 0. 628212      | 0              |               | 0 0   | 0                | 67. 00  |
| 68.00   | 06800 SPEECH PATHOLOGY                         | 0. 686956      | 0              |               | 0 0   | 0                | 68. 00  |
| 69. 00  | 06900 ELECTROCARDI OLOGY                       | 0. 080824      | 0              |               | 0 0   | 0                | 69. 00  |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS     | 0. 348774      | 0              |               | 0 0   | 0                | 71. 00  |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENTS          | 0. 130172      | 0              |               | 0 0   | 0                | 72. 00  |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS                | 0. 119557      | 0              |               | 0 0   | 0                | 73. 00  |
| 73. 01  | 07301 ONCOLOGY DRUGS                           | 0. 613644      | 0              |               | 0 0   | 0                | 73. 01  |
| 76.00   | 03020 CARDI OPULMONARY                         | 0. 874733      | 0              |               | 0 0   | 0                | 76. 00  |
|         | OUTPATIENT SERVICE COST CENTERS                |                |                |               |   |                  |         |
| 90.00   | 09000 CLI NI C                                 | 0. 438729      | 0              |               | 0   | 0                | 90.00   |
| 91.00   | 09100 EMERGENCY                                | 0. 268232      | 0              |               | 0   | 0                | 91.00   |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART)     | 0. 366641      | 0              |               | 0 0   | 0                | 92. 00  |
| 92. 01  | 09201 OBSERVATION BEDS (DISTINCT PART)         | 0. 000000      | 0              |               | 0   | 0                | ,       |
| 200.00  | Subtotal (see instructions)                    |                | 0              |               | 0 0   | 0                | 200. 00 |
| 201.00  | Less PBP Clinic Lab. Services-Program          |                |                |               | 0 0   | l                | 201. 00 |
|         | Only Charges                                   |                |                |               |   |                  |         |
| 202.00  | Net Charges (line 200 - line 201)              |                | O              | 1             | 0 0   | 0                | 202. 00 |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND  | VACCINE COST           |                            | CN. 15-1312 | From 01/01/2017<br>To 12/31/2017 | Part V Date/Time Pre 5/25/2018 5:2 | epared:<br>20 pm |
|--|------------------------|----------------------------|-------------|----------------------------------|------------------------------------|------------------|
|  |                        |                            | le XIX      | Hospi tal                        | Cost                               |                  |
|  |                        | sts                        | -           |                                  |                                    |                  |
| Cost Center Description  | Cost                   | Cost                       |             |                                  |                                    |                  |
|  | Reimbursed<br>Services | Reimbursed<br>Services Not |             |                                  |                                    |                  |
|  | Subject To             | Subject To                 |             |                                  |                                    |                  |
|  | Ded. & Coi ns.         | Ded. & Coins.              |             |                                  |                                    |                  |
|  | (see inst.)            | (see inst.)                |             |                                  |                                    |                  |
|  | 6.00                   | 7. 00                      | 1           |                                  |                                    |                  |
| ANCILLARY SERVICE COST CENTERS   |                        |                            |             |                                  |                                    |                  |
| 50.00 O5000 OPERATING ROOM   | 0                      | ) (                        |             |                                  |                                    | 50.00            |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM   | 0                      | ) (                        |             |                                  |                                    | 52.00            |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C   | 0                      | ) (                        |             |                                  |                                    | 54.00            |
| 55. 00   05500 RADI OLOGY-THERAPEUTI C   | 0                      | )                          |             |                                  |                                    | 55. 00           |
| 56.00   03630   ULTRA SOUND  | 0                      | (                          |             |                                  |                                    | 56. 00           |
| 57. 00   05700   CT   SCAN   | 0                      | )                          |             |                                  |                                    | 57. 00           |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)  | 0                      | )                          |             |                                  |                                    | 58. 00           |
| 60. 00   06000   LABORATORY  | 0                      | )                          |             |                                  |                                    | 60.00            |
| 66. 00 06600 PHYSI CAL THERAPY   | 0                      | ) (                        |             |                                  |                                    | 66. 00           |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 0                      | ) (                        |             |                                  |                                    | 67. 00           |
| 68. 00 06800 SPEECH PATHOLOGY  | 0                      | ) (                        |             |                                  |                                    | 68. 00           |
| 69. 00   06900   ELECTROCARDI OLOGY  | 0                      | )                          |             |                                  |                                    | 69. 00           |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | 0                      | )                          |             |                                  |                                    | 71. 00           |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS   | 0                      |                            |             |                                  |                                    | 72. 00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | 0                      | )                          | )           |                                  |                                    | 73. 00           |
| 73. 01   07301   0NCOLOGY   DRUGS  | 0                      |                            |             |                                  |                                    | 73. 01           |
| 76. 00 03020 CARDI OPULMONARY  | 0                      | )  (                       | )           |                                  |                                    | 76. 00           |
| 90. 00 09000 CLINIC  |                        |                            |             |                                  |                                    | 90.00            |
| 91. 00   09100  EMERGENCY  |                        |                            |             |                                  |                                    | 91.00            |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)  |                        |                            |             |                                  |                                    | 91.00            |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)  92. 01   09201   OBSERVATION BEDS (DISTINCT PART) |                        |                            |             |                                  |                                    | 92.00            |
| 200.00 Subtotal (see instructions)   |                        |                            |             |                                  |                                    | 200.00           |
| 201.00 Less PBP Clinic Lab. Services-Program   |                        |                            | 1           |                                  |                                    | 200.00           |
| Only Charges   |                        | [                          |             |                                  |                                    | 201.00           |
| 202.00 Net Charges (line 200 - line 201)   | 0                      |                            |             |                                  |                                    | 202. 00          |
| 232. 33 <sub>1</sub>   | 1                      | 1                          | 1           |                                  |                                    | 1-02.00          |

| Health Financial Systems                | IU HEALTH WHITE HOSPIT | <b>AL</b>       | In Lie                      | u of Form CMS-2552-10                 |
|---|------------------------|-----------------|-----------------------------|---------------------------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi                  | er CCN: 15-1312 | Peri od:<br>From 01/01/2017 | Worksheet D-1                         |
|   |                        |                 | To 12/31/2017               | Date/Time Prepared: 5/25/2018 5:20 pm |
|   |                        | Title XVIII     | Hospi tal                   | Cost                                  |

|                  |  | Title XVIII                           | Hospi tal         | 5/25/2018 5: 2<br>Cost  | O pm             |
|------------------|--|---------------------------------------|-------------------|-------------------------|------------------|
|                  | Cost Center Description  | II the Aviii                          | nospi tai         | Cost                    |                  |
|                  | DIST. ALL DROWNERS COMPONENTS  |                                       |                   | 1. 00                   |                  |
|                  | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS  |                                       |                   |                         |                  |
| 1.00             | Inpatient days (including private room days and swing-bed days   | s, excluding newborn)                 |                   | 2, 898                  | 1. 00            |
| 2.00             | Inpatient days (including private room days, excluding swing-  |                                       |                   | 2, 235                  | 2. 00            |
| 3.00             | Private room days (excluding swing-bed and observation bed day   | ys). If you have only pri             | vate room days,   | 0                       | 3. 00            |
| 4. 00            | do not complete this line.   | ad days)                              |                   | 1 427                   | 4. 00            |
| 5.00             | Semi-private room days (excluding swing-bed and observation be<br>Total swing-bed SNF type inpatient days (including private roo |                                       | 31 of the cost    | 1, 427<br>382           | 5. 00            |
| 0.00             | reporting period   | siii aaye, tiii eagii beesiiibe       | 0. 0. 1 0001      | 002                     | 0.00             |
| 6.00             | Total swing-bed SNF type inpatient days (including private roo   | om days) after December 3             | 31 of the cost    | 0                       | 6. 00            |
| 7 00             | reporting period (if calendar year, enter 0 on this line)  | n daya) through Dagambar              | 21 of the cost    | 201                     | 7 00             |
| 7. 00            | Total swing-bed NF type inpatient days (including private roor reporting period  | ii days) tiii ougii beceiibei         | 31 Of the Cost    | 281                     | 7. 00            |
| 8.00             | Total swing-bed NF type inpatient days (including private roor   | n days) after December 3 <sup>-</sup> | 1 of the cost     | 0                       | 8. 00            |
|                  | reporting period (if calendar year, enter 0 on this line)  |                                       |                   |                         |                  |
| 9.00             | Total inpatient days including private room days applicable to   | the Program (excluding                | swi ng-bed and    | 955                     | 9. 00            |
| 10. 00           | newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or   | nly (including private r              | nom days)         | 382                     | 10. 00           |
|                  | through December 31 of the cost reporting period (see instructions)  |                                       | Join day J        | 002                     | 10.00            |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or   |                                       | oom days) after   | 0                       | 11. 00           |
| 10.00            | December 31 of the cost reporting period (if calendar year, er   |                                       |                   |                         | 10.00            |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period                  | confy (including private              | e room days)      | 0                       | 12. 00           |
| 13. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX   | only (including private               | e room days)      | 0                       | 13. 00           |
|                  | after December 31 of the cost reporting period (if calendar ye   |                                       |                   |                         |                  |
| 14. 00           | Medically necessary private room days applicable to the Progra   | am (excluding swing-bed o             | days)             | 0                       | 14. 00           |
| 15. 00<br>16. 00 | Total nursery days (title V or XIX only) Nursery days (title V or XIX only)  |                                       |                   | 0                       | 15. 00<br>16. 00 |
| 10.00            | SWING BED ADJUSTMENT   |                                       |                   | 0                       | 10.00            |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service   | es through December 31 o              | f the cost        |                         | 17. 00           |
|                  | reporting period   |                                       |                   |                         |                  |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service reporting period  | es after December 31 of               | the cost          |                         | 18. 00           |
| 19. 00           | Medicald rate for swing-bed NF services applicable to services   | s through December 31 of              | the cost          | 155. 02                 | 19 00            |
|                  | reporting period   | -                                     |                   |                         |                  |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to services   | s after December 31 of th             | ne cost           | 0.00                    | 20. 00           |
| 21. 00           | reporting period Total general inpatient routine service cost (see instructions  | -)                                    |                   | 5, 494, 853             | 21. 00           |
| 21.00            | Swing-bed cost applicable to SNF type services through December  |                                       | na period (line   | 0, 494, 603             |                  |
| 22.00            | 5 x line 17)   | 5. 0. 0. the dest repert.             | ing porroa (irino |                         | 22.00            |
| 23. 00           | Swing-bed cost applicable to SNF type services after December  | 31 of the cost reporting              | g period (line 6  | 0                       | 23. 00           |
| 24. 00           | x line 18) Swing-bed cost applicable to NF type services through December  | s 21 of the cost reportion            | ag ported (line   | 43, 561                 | 24 00            |
| 24.00            | 7 x line 19)   | 31 of the cost reportin               | ig perrou (Trile  | 43, 301                 | 24.00            |
| 25. 00           | Swing-bed cost applicable to NF type services after December 3   | 31 of the cost reporting              | period (line 8    | 0                       | 25. 00           |
| 0, 00            | x line 20)   |                                       |                   | 000 070                 | 0, 00            |
| 26. 00<br>27. 00 | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost                             | (line 21 minus line 26)               |                   | 839, 278<br>4, 655, 575 |                  |
| 27.00            | PRI VATE ROOM DI FFERENTI AL ADJUSTMENT  | (Title 21 lilitius Title 20)          |                   | 4, 055, 575             | 27.00            |
| 28. 00           | General inpatient routine service charges (excluding swing-bed   | d and observation bed cha             | arges)            | 0                       | 28. 00           |
| 29. 00           | Private room charges (excluding swing-bed charges)   |                                       |                   | 0                       |                  |
| 30.00            | Semi -private room charges (excluding swing-bed charges)   | 11 200                                |                   | 0 000000                | 30.00            |
| 31. 00<br>32. 00 | General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)           | ÷ 11 ne 28)                           |                   | 0. 000000<br>0. 00      |                  |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)   |                                       |                   | 0.00                    |                  |
| 34.00            | Average per diem private room charge differential (line 32 mir   |                                       | tions)            | 0. 00                   | 34. 00           |
| 35.00            | Average per diem private room cost differential (line 34 x lin   | ne 31)                                |                   | 0.00                    |                  |
| 36. 00<br>37. 00 | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a      | and private room cost di              | fferential (line  | 0<br>4, 655, 575        | 36. 00<br>37. 00 |
| 37.00            | 27 minus Line 36)  | and private room cost ur              |                   | 4, 000, 575             | 37.00            |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                                       |                   |                         |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU   |                                       |                   | _                       |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see  | *                                     |                   | 2, 083. 03              |                  |
| 39. 00<br>40. 00 | Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program    | -                                     |                   | 1, 989, 294<br>0        | 39. 00<br>40. 00 |
|                  | Total Program general inpatient routine service cost (line 39  | ,                                     |                   | 1, 989, 294             |                  |
|                  |  |                                       | '                 |                         |                  |

| Heal th   | Financial Systems  | IU HEALTH WHIT    | F HOSPITAL      |                    | In Lie                           | eu of Form CMS-2                        | 2552-10          |
|---|--|-------------------|-----------------|--------------------|----------------------------------|---|------------------|
|   | ATION OF INPATIENT OPERATING COST  |                   |                 | CN: 15-1312        | Peri od:                         | Worksheet D-1                           |                  |
|   |  |                   |                 |                    | From 01/01/2017<br>To 12/31/2017 |   | pared:           |
|   |  |                   | <del></del>     | 200111             |                                  | 5/25/2018 5: 20                         |                  |
|   | Cost Center Description  | Total             | Total           | Average Per        | Hospi tal Program Days           | Cost<br>Program Cost                    |                  |
|   | oost center bescriptron  | Inpatient Cost    |                 |                    |                                  | (col. 3 x col.                          |                  |
|   |  |                   |                 | col . 2)           |                                  | 4)                                      |                  |
| 42.00   | NURSERY (title V & XIX only)   | 1.00              | 2.00            | 3.00               | 4.00                             | 5. 00                                   | 42. 00           |
| 42.00   | Intensive Care Type Inpatient Hospital Units   | U                 |                 | η 0. 0             | 0                                | 0                                       | 42.00            |
| 43.00   | INTENSIVE CARE UNIT  | 0                 | C               | 0.0                | 0 0                              | 0                                       | 43. 00           |
| 44. 00  | CORONARY CARE UNIT   |                   |                 |                    |                                  |   | 44. 00           |
| 45. 00<br>46. 00  | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT  |                   |                 |                    |                                  |   | 45. 00<br>46. 00 |
|   | OTHER SPECIAL CARE (SPECIFY)   |                   |                 |                    |                                  |   | 47. 00           |
|   | Cost Center Description  |                   |                 | 1                  |                                  |   |                  |
| 49.00   | Program inpatient ancillary service cost (Wk   | s+ D 2 col 2      | Line 200)       |                    |                                  | 1. 00<br>538, 160                       | 48. 00           |
| 48. 00<br>49. 00  | Total Program inpatient costs (sum of lines  |                   |                 | ons)               |                                  | 2, 527, 454                             |                  |
| 50. 00  | PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp.   | atient routine s  | ervices (from   | n Wkst. D, sum     | of Parts I and                   | 0                                       | 50. 00           |
| 51. 00  | Pass through costs applicable to Program inp.  | atient ancillary  | services (fr    | rom Wkst D s       | um of Parts II                   | 0                                       | 51. 00           |
|   | and IV)  | ,                 | 301 VI CC3 (11  | om wkst. b, s      | um or rurts ir                   |   |                  |
| 52. 00<br>53. 00  | Total Program excludable cost (sum of lines<br>Total Program inpatient operating cost exclu  |                   | ated, non-phy   | sician anesth      | etist, and                       | 0                                       |                  |
|   | medical education costs (line 49 minus line  |                   |                 |                    |                                  |   |                  |
| 54.00   | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges   |                   |                 |                    |                                  | 0                                       | 54. 00           |
| 55. 00  | Target amount per discharge  |                   |                 |                    |                                  | 0.00                                    |                  |
| 56.00   | Target amount (line 54 x line 55)  |                   |                 |                    |                                  | 0                                       | 56. 00           |
| 57. 00  | Difference between adjusted inpatient operat   | ing cost and tar  | get amount (I   | ine 56 minus       | line 53)                         | 0                                       | 57. 00           |
| 58. 00<br>59. 00  | Bonus payment (see instructions)<br>Lesser of lines 53/54 or 55 from the cost re   | mnounded by the   | 0.00            | 58. 00<br>59. 00   |                                  |   |                  |
| 37.00   | market basket  | portring period c | andring 1770, C | apaatea ana ee     | inpodrided by the                | 0.00                                    | 37.00            |
| 60.00   | Lesser of lines 53/54 or 55 from prior year  |                   |                 |                    |                                  | 0.00                                    |                  |
| 61.00   | 00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target |                   |                 |                    |                                  |   | 61. 00           |
|   | amount (line 56), otherwise enter zero (see  |                   | (TITIES 54 X    | 00), 01 1% 01      | the target                       |   |                  |
| 62. 00  | Relief payment (see instructions)  |                   |                 |                    |                                  | 0                                       | 62. 00           |
| 63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST |  |                   |                 |                    |                                  | 0                                       | 63. 00           |
| 64.00   | Medicare swing-bed SNF inpatient routine cos   | ts through Decem  | ber 31 of the   | e cost reporti     | ng period (See                   | 795, 717                                | 64. 00           |
| 65. 00  | <pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>  | ts after Decembe  | er 31 of the d  | cost reporting     | period (See                      | 0                                       | 65. 00           |
| 66. 00  | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi   | no costs (lino 4  | 4 plus line 4   | .E) (+; +l o V)/II | l only) For                      | 795, 717                                | 66. 00           |
| 00.00   | CAH (see instructions)   | `                 | •               | , ,                | 3,                               |   |                  |
| 67. 00  | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)  | e costs through   | December 31 c   | of the cost re     | porting period                   | 0                                       | 67. 00           |
| 68. 00  | Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)  | e costs after De  | ecember 31 of   | the cost repo      | rting period                     | 0                                       | 68. 00           |
| 69. 00  | Total title V or XIX swing-bed NF inpatient  |                   |                 |                    |                                  | 0                                       | 69. 00           |
| 70. 00  | PART III - SKILLED NURSING FACILITY, OTHER NU<br>Skilled nursing facility/other nursing facil  |                   |                 |                    |                                  |   | 70. 00           |
| 71. 00  | Adjusted general inpatient routine service c   | -                 |                 |                    |                                  |   | 71. 00           |
| 72. 00  | Program routine service cost (line 9 x line  |                   |                 |                    |                                  |   | 72. 00           |
| 73. 00<br>74. 00  | Medically necessary private room cost application. Total Program general inpatient routine serv  |                   |                 |                    |                                  |   | 73. 00<br>74. 00 |
| 75. 00  | Capital-related cost allocated to inpatient  |                   |                 |                    | art II, column                   |   | 75. 00           |
| 76. 00  | 26, line 45)<br> Per diem capital-related costs (line 75 ÷ li  | ne 2)             |                 |                    |                                  |   | 76. 00           |
| 77. 00  | Program capital -related costs (line 9 x line  |                   |                 |                    |                                  |   | 77. 00           |
| 78.00   | Inpatient routine service cost (line 74 minu   | ,                 |                 |                    |                                  |   | 78. 00           |
| 79. 00<br>80. 00  | Aggregate charges to beneficiaries for exces<br>Total Program routine service costs for comp.  |                   |                 |                    | us line 70)                      |   | 79. 00<br>80. 00 |
| 81.00   | 1  |                   | ot iimi tati Ul | . (11116-70-111111 | us IIIIC /7)                     |   | 81.00            |
| 82. 00  | Inpatient routine service cost limitation (  | ine 9 x line 81)  |                 |                    |                                  |   | 82. 00           |
| 83.00   | Reasonable inpatient routine service costs (   |                   | 5)              |                    |                                  |   | 83.00            |
| 84. 00<br>85. 00  | Program inpatient ancillary services (see in Utilization review - physician compensation   |                   | is)             |                    |                                  |   | 84. 00<br>85. 00 |
| 86. 00  |  |                   |                 |                    |                                  |   | 86. 00           |
|   | PART IV - COMPUTATION OF OBSERVATION BED PASS  | S THROUGH COST    |                 |                    |                                  |   |                  |
| 87.00   | Total observation bed days (see instructions   |                   | Line 2)         |                    |                                  | 3 093 03                                |                  |
| 88. 00<br>89. 00  | Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se   |                   | 1111e 2)        |                    |                                  | 2, 083. 03<br>1, 683, 088               |                  |
|   | (30)   |                   |                 |                    |                                  | , |                  |

| Health Financial Systems                      | IU HEALTH WHI | TE HOSPITAL    |            | In Lie                           | u of Form CMS-2                   | 2552-10 |
|---|---------------|----------------|------------|----------------------------------|-----------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST       |               | Provi der CC   |            | Peri od:                         | Worksheet D-1                     |         |
|   |               |                |            | From 01/01/2017<br>To 12/31/2017 | Date/Time Prep<br>5/25/2018 5: 20 |         |
|   |               | Title          | XVIII      | Hospi tal                        | Cost                              |         |
| Cost Center Description                       | Cost          | Routine Cost   | column 1 ÷ | Total                            | Observation                       |         |
|   |               | (from line 21) | column 2   | Observati on                     | Bed Pass                          |         |
|   |               |                |            | Bed Cost (from                   | Through Cost                      |         |
|   |               |                |            | line 89)                         | (col. 3 x col.                    |         |
|   |               |                |            |                                  | 4) (see                           |         |
|   |               |                |            |                                  | instructions)                     |         |
|   | 1.00          | 2. 00          | 3. 00      | 4. 00                            | 5. 00                             |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH ( | COST          |                |            |                                  |                                   |         |
| 90.00 Capital -related cost                   | 1, 018, 280   | 5, 494, 853    | 0. 18531   | 5 1, 683, 088                    | 311, 901                          | 90.00   |
| 91.00 Nursing School cost                     | 0             | 5, 494, 853    | 0.00000    | 0 1, 683, 088                    | 0                                 | 91.00   |
| 92.00 Allied health cost                      | 0             | 5, 494, 853    | 0.00000    | 0 1, 683, 088                    | 0                                 | 92.00   |
| 93.00 All other Medical Education             | 0             | 5, 494, 853    | 0. 00000   | 1, 683, 088                      | 0                                 | 93. 00  |

| Health Financial Systems                | IU HEALTH WHITE HOSPITAL | In Lie                      | u of Form CMS-2552-10                 |
|---|--------------------------|-----------------------------|---------------------------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-1312   | Peri od:<br>From 01/01/2017 | Worksheet D-1                         |
|   |                          | To 12/31/2017               | Date/Time Prepared: 5/25/2018 5:20 pm |
|   | Title XIX                | Hospi tal                   | Cost                                  |

| Title XIX  |        |  |   | 10 12/31/2017      | 5/25/2018 5:20 |        |
|--|--------|--|---|--------------------|----------------|--------|
| PART 1 - ALL PROVIDER COMPONENTS  Impollant in DAYS  Impollant Government of the Component  |        |  | Title XIX                               | Hospi tal          |                |        |
| MAPTITE DAYS   Impatient days (including private room days and swing-bed days, excluding neeborn)   2,898   1.00   Impatient days (including private room days, excluding swing-bed and newborn days)   2,233   2.00   1.   |        | Cost Center Description  |   |                    |                |        |
| NATIENT DAYS   |        | DADT I ALL DDOVI DED COMPONENTS                                |   |                    | 1. 00          |        |
| December 3 of the cost reporting period (From Called SW)   Provide room days and period and newborn days)   2,285   2,00   |        |  |   |                    |                |        |
| 1.00   Private room days (excluding swing-bed and observation bed days). If you have only private room days.   0   3.00  | 1.00   |  | s, excluding newborn)                   |                    | 2, 898         | 1.00   |
| on ont complete this line.  Semi-private room days (excluding awing-bed and observation bed days) through December 31 of the cost 382 for coporting period of reporting period of reportin | 2.00   | Inpatient days (including private room days, excluding swing-  | ped and newborn days)                   |                    | 2, 235         | 2. 00  |
| 1, 427 4.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (including private) room days) after December 31 of the cost reporting period (including private) room days) after December 31 of the cost reporting period (including private) room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting December 31 | 3.00   |  | ys). If you have only pr                | ivate room days,   | 0              | 3. 00  |
| 10.0 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) rotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) rotal in swing-bed NF type inpatient days including private room days applicable to the Program (excluding swing-bed and normal year) reporting period (if calendar year, enter 0 on this line) rotal in swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) rotal period (if calendar year, enter 0 on this line) rotal period (if calendar year, enter 0 on this line) rotal period (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year, enter 0 on this line) rotal pursuance (if calendar year,  | 4 00   |  |   |                    | 4 407          | 4 00   |
| reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line) to the period (if callendar year, enter 0 on this line) to the period (if callendar year, enter 0 on this line) to the period (if callendar year, enter 0 on this line) to the period (if callendar year, enter 0 on this line) to the period (if callendar year, enter 0 on this line) to the period (if callendar year, enter 0 on this line) reporting period (if callendar year, enter 0 on this line) reporting period (if callendar year, enter 0 on this line) reporting period (if callendar year, enter 0 on this line) revolution days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) through December 31 of the cost reporting period (if callendar year) through December 31 of the cost reporting period (if the year enter 0 on this line) should be dead of the year period (if callendar year, enter 0 on this line) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) which year year year year year year year year   |        |  |   | r 21 of the cost   |                | 1      |
| 100 Total saing-bed SNF type inpattient days (including private room days) after December 31 of the cost reporting period (if called reporting period (if called reporting period (in called reporting reporting re | 3.00   |  | on days) through becembe                | i si di the cost   | 302            | 3.00   |
| reporting period (if calendar year, enter 0 on this line)  Total simple-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  Total simple-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period  Total inpatient days including private room days applicable to the Program (excluding swing-bed and  O 9.00  Sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  Sing-bed SNF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  So sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  So sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  Introdup December 31 of the cost reporting period (if calendar year, enter 0 on this line)  So sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  Introdup December 31 of the cost reporting period (if calendar year, enter 0 on this line)  So sing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  Introdup December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Norting Valvas (title V or XIX only)  Norting Valvas (title V or XIX only)  Norting Valvas (title V or XIX only)  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (in a fact for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 5 x line 10)  Norting December 31 of the cost reporting period (line 6 x line 10)  Norting December 31 of the cost reporting period (line 6 x line 10)  Norting December 31 of the cost re | 6. 00  |  | om days) after December                 | 31 of the cost     | l o            | 6. 00  |
| or Feporting period  Total impacted Mr type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total impaction days including private room days applicable to the Program (excluding swing-bed and newborn days)  Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days)  Union bed SWF type inpatient days applicable to title XWIII only (including private room days) after become rate of the swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) after become rate of the swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) after become rate of the swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after become rate of the cost reporting period (if calendar year, enter 0 on this line)  Medically necessary private room days applicable to titles V or XIX only (including private room days)  Union of the cost reporting period (if calendar year, enter 0 on this line)  Medically necessary private room days applicable to the Program (excluding swing-bed days)  Union of the cost reporting period (if calendar year, enter 0 on this line)  Medically necessary private room days applicable to the Program (excluding swing-bed days)  Union of the cost reporting period (if calendar year, enter 0 on this line)  Medically necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Medically necessary private room days applicable to services through December 31 of the cost reporting period (if a calendar year, enter 0 on this line)  Medically necessary private room days applicable to services after December 31 of the cost reporting period (if a calendar year, enter 0 on this line)  Medically necessary applicable to SWF type services after December 31 of the cost reporting period (if a calendar year, enter 0 on the s |        | reporting period (if calendar year, enter 0 on this line)      | 3 ,                                     |                    |                |        |
| 100 Total sawing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 101 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 102 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after shrough December 31 of the cost reporting period (see instructions) 102 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after shrough December 31 of the cost reporting period (see instructions) 103 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after shrough December 31 of the cost reporting period (see instructions) 103 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 104 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 105 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 106 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 107 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 108 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 109 Swing-bed SNF services applicable to services through December 31 of the cost reporting period (see Swing-bed NF services applicable to services after December 31 of the cost reporting period (see Swing-bed NF services applicable to services after December 31 of the cost reporting period (line Swiline Swing-bed SNF services after December 31 of the cost reporting period (line Swiline Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swiline Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swiline Swing-bed cost applicable to NF type services fro | 7.00   |  | m days) through December                | 31 of the cost     | 281            | 7. 00  |
| reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) 2.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 2.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 2.02 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 2.03 Total nursery days (title V or XIX only) 2.04 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 2.05 Total nursery days (title V or XIX only) 2.06 Nursery days (title V or XIX only) 2.07 Swin Swing-bed DAUDSTMENT 2.08 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 3.07 Swing-bed DAUDSTMENT 3.08 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 3.09 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x III nurse) 3.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x III nurse) 3.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x III nurse) 3.02 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x III | 0.00   |  |   | 1 -6               |                | 0.00   |
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| newborn days)  newborn days applicable to title XVIII only (including private room days) after possible days applicable to title XVIII only (including private room days)  newborn days)  newborn days applicable to titles V or XIX only (including private room days)  newborn days)  newborn days applicable to titles V or XIX only (including private room days)  newborn days)  newborn days applicable to titles V or XIX only (including private room days)  newborn days)  newborn days  newborn days)  newborn days  newbo | 9. 00  |  | o the Program (excluding                | swing-bed and      | 0              | 9.00   |
| through December 31 of the cost reporting period (see instructions)  10. 05 wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  2. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  3. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  4. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  4. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  5. 00 Total nursery days (title V or XIX only)  6. 00 Nursery days (title V or XIX only)  7. 00 Medicar rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  8. 00 Medical of rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  9. 00 Medical of rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1. 00 Total general inpatient routine service cost (see instructions)  5. 404, 803  5. 404, 803  6. 503  6. 504  6. 505  6. 507  6. 508  6. 608   |        |  |   |                    |                |        |
| 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  2.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  3.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  4.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  5.01 Total nursery days (title V or XIX only)  6.02 Swing-bed DAUJSTMENT  7.03 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  8.00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  9.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Total general inpatient routine service cost (see instructions)  3.01 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  3.02 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  4.03 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  5.04 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  6.05 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18)  6.06 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6.07 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6.08 Swing-bed cost applicable to NF type service | 10.00  |  |   | oom days)          | 0              | 10. 00 |
| December 31 of the cost reporting period (if calendar year, enter 0 on this line)  2.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  3.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  4.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  4.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  5.00 Total nursery days (title V or XIX only)  6.00 Nursery days (title V or XIX only)  7.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  8.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  9.00 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  9.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Total querial inpatient routine service cost (see instructions)  5.494,853  6.40 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 S X Iline 17)  5.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 S X Iline 17)  6.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 S X Iline 10)  6.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 S X Iline 20)  6.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 S X Iline 20)  6.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 A 655, 575 December 31 of the cost reporting period (line 8 S 30 December 31 of the cost reporting period (line 8 S 30 December 31 of the cost reporting period (line 8 S 30 December 31 of the c | 44 00  |  |   |                    |                | 44 00  |
| 2.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period of after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 4.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 5.00 Total nursery days (title V or XIX only) 6.00 Nursery days (title V or XIX only) 7.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 8.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 9.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 9.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 9.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost 9.00 Swing-bed cost applicable to SNF type services through December 31 of the cost 9.00 Swing-bed cost applicable to SNF type services through December 31 of the cost 9.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 9.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 9.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 9.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 9.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 9.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 9.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 9.00 Swin | 11.00  |  |   | oom days) arter    | ال             | 11.00  |
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| after December 31 of the cost reporting period (If cal endar year, enter 0 on this line)  10 Medically necessary private room days applicable to the Program (excluding swing-bed days)  11 A. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  12 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  13 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  14 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  15 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  15 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  15 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  15 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  16 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  17 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  18 Ming-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X line 17)  20 Medicare rate for swing-bed to SNF type services after December 31 of the cost reporting period (line 6 X line 18)  21 Mine 19)  22 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 X line 18)  23 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 X line 19)  25 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 X line 19)  26 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 X line 19)  27 Mine 19)  28 Ming-bed cost applicable to NF type services after December 31 of the cost reporting per |        |  | · ···· y (· ····· · · · · · · · · · · · |                    |                |        |
| Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14,00   | 13.00  |  |   |                    | 0              | 13. 00 |
| 10 Total nursery days (title V or XIX only)  10 Total nursery days (title V or XIX only)  11 SWING BED ADJUSTMENT  12 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line ground)  13 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line ground)  15 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line ground)  16 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line ground)  17 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line ground)  18 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line ground)  19 Medicaid rate for swing-bed NF services through December 31 of the cost reporting period (line ground)  10 Total general inpatient routine service safter December 31 of the cost reporting period (line ground)  11 No Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line ground)  12 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line ground)  13 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line ground)  14 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line ground)  15 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line ground)  16 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line ground)  17 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line ground)  18 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line ground)  18 No Swing-bed cost applicable t |        |  |   |                    | _              |        |
| Nursery days (title V or XIX only)   | 14.00  |  | am (excluding swing-bed                 | days)              |                |        |
| SWING BED ADJUSTMENT  7. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period of Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period of SNF services applicable to services after December 31 of the cost reporting period of Total general inpatient routine service cost (see instructions)  2. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  3. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  4. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  4. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  5. 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6. 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6. 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  7. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  8. 00 Semenal inpatient routine service cost for swing-bed cost (line 21 minus line 26)  8. 00 General inpatient routine service cost for swing-bed cost (line 21 minus line 26)  8. 00 General inpatient routine service cost/charges (excluding swing-bed charges)  9. 00 Dost swing-brivate room charges (excluding swing-bed charges)  9. 00 Ostal swing-bed cost (see instructions)  9. 00 Ostal swing-bed cost differential (line 29 * line 3)  9. 00 Ostal swing-bed cost differential (line 30 * line 4)  9. 00 Ostal swing-bed cost differential (line 30 * line 4)  9. 0 |        |  |   |                    | -              |        |
| Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (18.00)  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed t | 10.00  |  |   |                    |                | 10.00  |
| Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting period medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting period period reporting period (Inc.)  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Inc.)  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Inc.)  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (Inc.)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (Inc.)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc.)  Wing-bed cost applicable to NF type services through December 31 of the cost reporting period (Inc.)  Note of the cost reporting period (Inc.)  Wing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc.)  Note of the cost reporting period (Inc.)  Wing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc.)  Note of the cost reporting period (Inc.)  Wing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc.)  Note of the cost reporting period (Inc.)  Wing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc.)  Note of the cost reporting period (Inc.)  Wing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc.)  Note of the cost reporting period (Inc.)  Note of the cost reporting period (Inc.)  Wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (Inc.)  Note of | 17. 00 |  | es through December 31 o                | f the cost         |                | 17. 00 |
| reporting period  0.00 Medical of rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  1.00 Medical of rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Total general inpatient routine service cost (see instructions)  2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  3.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  4.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6.00 Total swing-bed cost (see instructions)  7.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  8.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 Average perivate room charges (excluding swing-bed charges)  9.00 Private room charges (excluding swing-bed charges)  9.00 Average perivate room per diem charge (line 29 * line 3)  9.00 Average perivate room per diem charge (line 30 * line 4)  9.00 Average perivate room per diem charge (line 30 * line 4)  9.00 Average perivate room charge differential (line 32 minus line 33) (see instructions)  9.00 General inpatient routine service cost periods of swing-bed cost and private room cost differential (line 3 x line 31)  9.00 Average per diem private room cost differential (line 3 x line 35)  9.00 Program general inpatient routine service cost per diem (see instructions)  9.00 Program general inpatient routine service cost periodes of swing-bed cost and private room cost differential (line 4, 655, 575)  9.00 ON Medicala general inpatient routine service cost periodes of swing-bed cost and  |        |  |   |                    |                |        |
| Medicaid a Tate for swing-bed NF services applicable to services through December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line parent in patient routine service cost (see instructions)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line parent in patient routine service cost (see instructions)  Medicaid Tate for swing-bed NF services after December 31 of the cost reporting period (line parent in patient routine service cost period (line parent in patient routine service cost papicable to SNF type services after December 31 of the cost reporting period (line parent in patient routine service cost papicable to NF type services after December 31 of the cost reporting period (line parent in patient routine service cost net of swing-bed cost (line 21 minus line 26)  Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line parent in patient routine service cost net of swing-bed cost (line 21 minus line 26)  Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line parent in patient routine service cost net of swing-bed cost (line 21 minus line 26)  Magnetal inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  Magnetal inpatient routine service cost net of swing-bed and observation bed charges)  Magnetal inpatient routine service cost (line 29 + line 3)  Magnetal inpatient routine service cost (line 29 + line 3)  Magnetal inpatient routine service cost line 30 + line 4)  Magnetal inpatient routine service cost net of swing-bed cost and private room cost differential (line parentine service cost and private room cost differential (line parentine service cost net of swing-bed cost and private room cost differential (line parentine service cost net of  | 18. 00 |  | es after December 31 of                 | the cost           |                | 18. 00 |
| reporting period  0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Total general inpatient routine service cost (see instructions)  2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  3.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  4.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  5.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  6.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  7 x line 19)  6.00 Total swing-bed cost (see instructions)  7.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  8.01 PRIVATE ROMD IFFERENTIA ADJUSTMENT  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Os Semi-private room charges (excluding swing-bed charges)  9.00 Os Semi-private room charges (excluding swing-bed charges)  9.01 Os Os General inpatient routine service cost/charge ratio (line 27 + line 28)  9.02 Os Average peri dem private room per diem charge (line 30 + line 4)  9.03 Os  | 10 00  |  | the cost                                | 155 02             | 10 00          |        |
| Nedical drafe for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period period (line source) period ( | 19.00  |  | s through becember 31 or                | the cost           | 155.02         | 19.00  |
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| 5 x line 17) 3.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 4.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 43, 561 24.00 7 x line 19) 5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 6.00 Total swing-bed cost (see instructions) 839, 278 26.00 (See and inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8.00 General inpatient routine service cost net of swing-bed and observation bed charges) 8.00 Semi-private room charges (excluding swing-bed charges) 9.00 Private room charges (excluding swing-bed charges) 9.00 Average perivate room per diem charge (line 29 + line 3) 9.00 Average perivate room per diem charge (line 29 + line 3) 9.00 Average peridem private room cost differential (line 30 + line 4) 9.00 Average per diem private room cost differential (line 34 x line 31) 9.00 Average per diem private room cost differential (line 34 x line 31) 9.00 Private room cost differential (line 3 x line 35) 9.00 Private room cost differential (line 3 x line 35) 9.00 Average per diem private room cost differential (line 3 x line 35) 9.00 Private room cost differential (line 3 x line 35) 9.00 Average per diem private room cost differential (line 3 x line 35) 9.00 Private room cost differential (line 3 x line 35) 9.00 Program (line 14 x line 35) 9.00 Program general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost tent the Program (line 14 x line 35) 9.00 Program general inpatient routine service cost tent the Program (line 14 x line 35) 9.00 Program general inpatient routine service to cost (line 9 x line 38) 9.00 Program general inpatient routine service to cost (line 9 x line 38) 9.00 Program general inpatient routine service to cost (line 9 x line 38) 9.00 Program general inpatient routine service to cost (line 9 x line 38) 9.00 Program general | 21. 00 |  |   |                    |                |        |
| 3.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 4.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 6.00 Total swing-bed cost (see instructions) 6.00 Total swing-bed cost (see instructions) 7.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 8.00 Private room charges (excluding swing-bed charges) 9.00 Private room charges (excluding swing-bed charges) 9.00 Private room charges (excluding swing-bed charges) 9.00 Average private room per diem charge (line 29 * line 3) 9.00 Average per diem private room per diem charge (line 29 * line 3) 9.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 9.00 Average per diem private room cost differential (line 32 minus line 33) 9.00 Average per diem private room cost differential (line 34 x line 31) 9.00 Average per diem private room cost differential (line 3 x line 35) 9.00 Private room cost differential adjustment (line 3 x line 35) 9.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY 9.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 9.00 Adjusted general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost tine 9 x line 36 9.00 Program general inpatient routine service cost tine of the Program (line 14 x line 35) 9.00 On Medically necessary private room cost applicable to the Program (line 14 x line 35) 9.00 On Medically necessary private room cost applicable to the Program (line 14 x line 35) 9.00 On Medically necessary private room cost applicable to the Program (line 14 x line 35)   | 22. 00 |  | er 31 of the cost report                | ing period (line   | 0              | 22.00  |
| x line 18)  4.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6.00 Total swing-bed cost (see instructions)  8.39, 278 d. (6.00 PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  8.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  9.00 Private room charges (excluding swing-bed charges)  1.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  1.00 Average private room per diem charge (line 29 ÷ line 3)  1.00 Average semi-private room per diem charge (line 29 ÷ line 3)  1.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  1.00 Average per diem private room cost differential (line 34 x line 31)  1.00 Average per diem private room cost differential (line 34 x line 31)  1.00 Private room cost differential adjustment (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Adjusted general inpatient routine service cost per diem (see instructions)  1.00 Adverdade general inpatient routine service cost per diem (see instructions)  1.01 Average per diem private room cost differential (line 38)  1.02 Average per diem private room cost differential (line 38)  1.03 Average per diem private room cost differential (line 30 x line 35)  1.00 Average per diem private room cost differential (line 30 x line 35)  1.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  2.00 Average per diem private room cost net of swing-bed cost and private room co | 23. 00 |  | 31 of the cost reporting                | n period (line 6   | 0              | 23 00  |
| 7 x line 19)  5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  6.00 Total swing-bed cost (see instructions)  839, 278  7.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  8.00 Semi-private room charges (excluding swing-bed charges)  9.00 Osemi-private room charges (excluding swing-bed charges)  9.00 Average private room per diem charge (line 29 + line 28)  9.00 Average semi-private room per diem charge (line 29 + line 3)  9.00 Average semi-private room per diem charge (line 30 + line 4)  9.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Frivate room cost differential adjustment (line 3 x line 35)  9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Average per diem private room cost differential (line 34 x line 35)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Average per diem private room cost differential (line 34 x line 35)  9.00 Average per diem private room cost differential (line 34 x line 35)  9.00 Average per diem private room cost differential (line 34 x line 35)  9.00 Average per diem private room cost differential (line 34 x line 35)  9.00 Average per diem private room cost differential (line 34 x line 35)  9.00 Average per diem private room cost differential (line 34 x line 35)  9.00  | 20.00  |  | or or the door roper trin               | g por rou (11110 0 |                | 20.00  |
| Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  7. 00 Total swing-bed cost (see instructions)  839, 278  84, 655, 575  7. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  839, 278  4, 655, 575  7. 00 PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  8. 00 Private room charges (excluding swing-bed and observation bed charges)  9. 00 Private room charges (excluding swing-bed charges)  9. 00 Semi-private room charges (excluding swing-bed charges)  9. 00 Semi-private room charges (excluding swing-bed charges)  9. 00 Average private room per diem charge (line 29 + line 3)  9. 00 Average per diem private room per diem charge (line 29 + line 3)  9. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  9. 00 Average per diem private room cost differential (line 34 x line 31)  9. 00 Average per diem private room cost differential (line 34 x line 31)  9. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  7. 00 Minus line 36)  9. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8. 00 Adjusted general inpatient routine service cost per diem (see instructions)  9. 00 Ond Medically necessary private room cost applicable to the Program (line 14 x line 35)  9. 00 Ond Medically necessary private room cost applicable to the Program (line 14 x line 35)   | 24.00  |  | r 31 of the cost reporti                | ng period (line    | 43, 561        | 24. 00 |
| x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Pri vate room charges (excluding swing-bed charges) O.00 Semi-private room charges (excluding swing-bed charges) O.00 Semi-private room charges (excluding swing-bed charges) O.00 O.00 Average private room per diem charge (line 29 ÷ line 3) O.00 Average semi-private room per diem charge (line 30 ÷ line 4) O.00 Average per diem private room cost differential (line 34 x line 31) O.00 Average per diem private room cost differential (line 34 x line 31) O.00 O.00 O.00 O.00 O.00 O.00 O.00 O.0  |        |  |   |                    |                |        |
| Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  ROUND DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Comeral inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total swing-bed cost (line 21 minus line 26)  4, 655, 575  27. 00  28. 00  28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. 00  21. 00  22. 00  23. 00  31. 00  32. 00  32. 00  34. 00  35. 00  36. 00  37. 00  37. 00  38. 00  38. 00  39. 00  9. 0 | 25.00  |  | 31 of the cost reporting                | period (line 8     | ال             | 25.00  |
| 7. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  8. 00 Private ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Private room charges (excluding swing-bed charges)  9. 00 Semi-private room charges (excluding swing-bed charges)  9. 00 Average private room per diem charge (line 29 ÷ line 3)  1. 00 Average per diem private room per diem charge (line 30 ÷ line 4)  4. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  5. 00 Average per diem private room cost differential (line 34 x line 31)  9. 00 Average per diem private room cost differential (line 34 x line 31)  9. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  9. 00 Average per diem private room cost differential (line 37 minus line 38)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem private room cost differential (line 3 x line 35)  9. 00 Average per diem priva | 26. 00 |  |   |                    | 839, 278       | 26. 00 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Coeneral inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. 00  29. 00  20 | 27. 00 |  | (line 21 minus line 26)                 |                    |                |        |
| 9.00 Private room charges (excluding swing-bed charges) 0.00 Semi-private room per diem charge (line 27 ÷ line 28) 0.00 Semi-private room per diem charge (line 30 ÷ line 3) 0.00 Semi-private room per diem charge (line 30 ÷ line 4) 0.00 Semi-private room per diem charge (line 30 ÷ line 4) 0.00 Semi-private room charge differential (line 32 minus line 33)(see instructions) 0.00 Semi-private room cost differential (line 34 x line 31) 0.00 Semi-private room cost differential (line 34 x line 31) 0.00 Semi-private room cost differential (line 34 x line 31) 0.00 Semi-private room cost differential (line 34 x line 31) 0.00 Semi-private room cost differential (line 34 x line 31) 0.00 Semi-private room cost differential (line 34 x line 31) 0.00 Semi-private room cost differential (line 34 x line 31) 0.00 Semi-private room per diem private room cost differential (line 34 x line 31) 0.00 Semi-private room per diem private room cost differential (line 34 x line 31) 0.00 Semi-private room per diem private room cost differential (line 4, 655, 575) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 32 * line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room per diem charge (line 30 ÷ line 31) 0.00 Semi-private room charge (line 30 ÷ li |        | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT                           |   |                    |                |        |
| 0.00 Semi-private room charges (excluding swing-bed charges) 1.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 2.00 Average private room per diem charge (line 29 ÷ line 3) 3.00 Average semi-private room per diem charge (line 30 ÷ line 4) 4.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 5.00 Average per diem private room cost differential (line 34 x line 31) 6.00 Private room cost differential adjustment (line 3 x line 35) 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575) 7.00 FART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost (line 9 x line 38) 9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0  | 28. 00 |  | d and observation bed ch                | arges)             |                | ł      |
| 1.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 2.00 Average private room per diem charge (line 29 ÷ line 3) 3.00 Average semi-private room per diem charge (line 30 ÷ line 4) 4.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 6.00 Average per diem private room cost differential (line 34 x line 31) 6.00 Private room cost differential adjustment (line 3 x line 35) 6.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575) 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575) 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost (line 9 x line 38) 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0   | 29. 00 |  |   |                    | l              | 1      |
| 2.00 Average private room per diem charge (line 29 ÷ line 3) 3.00 Average semi-private room per diem charge (line 30 ÷ line 4) 4.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 5.00 Average per diem private room cost differential (line 34 x line 31) 6.00 Private room cost differential adjustment (line 3 x line 35) 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575) 7.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost (line 9 x line 38) 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 Medically necessary private room cost differential (line 2, 0.00) 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 Average per diem charge (line 30 ÷ line 3) 0.00 32.00 0.00 Average semi-private room per diem charge (line 4) 0.00 32.00 0.00 Average semi-private room per diem charge (line 4) 0.00 32.00 0.00 Average semi-private room per diem charge (line 4) 0.00 32.00 0.00 Average semi-private room per diem charge (line 4) 0.00 32.00 0.00 Average semi-private room per diem charge (line 4) 0.00 32.00 0.00 Average semi-private room per diem charge (line 32 minus line 33) 0.00 34.00 0.00 Average semi-private room per diem charge (line 32 minus line 33) 0.00 34.00 0.00 Average semi-private room per diem charge (line 32 minus line 33) 0.00 34.00 0.00 Average semi-private room per diem charge (line 32 minus line 33) 0.00 34.00 0.00 Average per diem private room cost differential (line 4, 655, 575) 0.00 34.00 0.00 Average per diem private room per diem charge (line 32 minus line 33) 0.00 34.00 0.00 Average per diem private room cost differential (line 32 minus line 33) 0.00 34.00 0.00 Average per diem private room cost diff |        |  | · Lino 29)                              |                    |                | ł      |
| Average semi-private room per diem charge (line 30 ÷ line 4)  4.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  5.00 Average per diem private room cost differential (line 34 x line 31)  6.00 Private room cost differential adjustment (line 3 x line 35)  6.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  7.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Average per diem private room cost differential (line 4, 655, 575)  9.00 Program general inpatient routine service cost per diem (see instructions)  9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  34.00  35.00  36.00  37.00  | 32. 00 |  | - 111le 20)                             |                    |                | ł      |
| 5.00 Average per diem private room cost differential (line 34 x line 31)  6.00 Private room cost differential adjustment (line 3 x line 35)  7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Average per diem private room cost differential (line 4, 655, 575)  37.00  37.00  38.00  Adjusted general inpatient routine service cost per diem (see instructions)  9.00 Program general inpatient routine service cost (line 9 x line 38)  0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 decided to the program (line 14 x line 35)  0.00 decided to the program (line 14 x line 35)  | 33. 00 |  |   |                    |                | •      |
| 6.00 Private room cost differential adjustment (line 3 x line 35)  7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 655, 575)  7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 655, 575)  8.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Adjusted general inpatient routine service cost per diem (see instructions)  9.00 Program general inpatient routine service cost (line 9 x line 38)  0 39.00  0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 4.655, 575  37.00  | 34.00  |  | nus line 33)(see instruc                | tions)             |                | ı      |
| 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 57, 575) 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,083.03 38.00 9.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00   | 35. 00 |  |   |                    |                |        |
| 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Adjusted general inpatient routine service cost per diem (see instructions)  9.00 Program general inpatient routine service cost (line 9 x line 38)  0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00  | 36.00  |  | Efonon+!-! (!!                          |                    | 36.00          |        |
| PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Adjusted general inpatient routine service cost per diem (see instructions)  9.00 Program general inpatient routine service cost (line 9 x line 38)  0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 40.00   | 37. 00 |  | rrerential (line                        | 4, 655, 575        | 37.00          |        |
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  8.00 Adjusted general inpatient routine service cost per diem (see instructions)  9.00 Program general inpatient routine service cost (line 9 x line 38)  0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 40.00  |        |  |   |                    |                | 1      |
| 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,083.03 38.00 9.00 Program general inpatient routine service cost (line 9 x line 38) 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00  |        |  | JSTMENTS                                |                    |                |        |
| 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00   | 38. 00 |  |   |                    | 2, 083. 03     | 38. 00 |
|  | 39. 00 | ,  | -                                       |                    |                | 39. 00 |
| 1. DO   TOTAL Program general inpatient routine service cost (fine 39 + 11Me 40)   | 40.00  |  |   |                    |                | 40.00  |
|  | 41. 00 | Tiotal Program general inpatient routine service cost (line 39 | + iine 40)                              |                    | ) 0            | 41.00  |

|                                      | Financial Systems  | IU HEALTH WHI                     |               |                                |  | eu of Form CMS-                           |                                      |
|--------------------------------------|--|-----------------------------------|---------------|--------------------------------|--|---|--------------------------------------|
| COMPU                                | FATION OF INPATIENT OPERATING COST   |                                   | Provi der (   | CCN: 15-1312                   | Peri od:<br>From 01/01/2017<br>To 12/31/2017 | Worksheet D-1 Date/Time Pre 5/25/2018 5:2 | pared:                               |
|                                      | Cost Center Description  | Total<br>Inpatient Cost           | Total         | Average Person (col. 1 col. 2) | 3  | Program Cost<br>(col. 3 x col.<br>4)      |                                      |
| 42.00                                | MIDSERY (+; +Lo V & VIV only)  | 1.00                              | 2. 00         | 3.00                           | 4.00   | 5. 00                                     | 42.00                                |
| 42. 00                               | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units  | 0                                 |               | J <sub>1</sub> 0.              | 00 0   | 0   | 42.00                                |
| 43. 00<br>44. 00<br>45. 00<br>46. 00 | INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT   | 0                                 | 1             | 0.                             | 00 0   | 0   | 43. 00<br>44. 00<br>45. 00<br>46. 00 |
|                                      | OTHER SPECIAL CARE (SPECIFY) Cost Center Description   |                                   |               |                                |  |   | 47. 00                               |
|                                      | ·  |                                   |               |                                |  | 1.00                                      |                                      |
| 48. 00<br>49. 00                     | Program inpatient ancillary service cost (Wk:<br>Total Program inpatient costs (sum of lines a<br>PASS THROUGH COST ADJUSTMENTS  |                                   |               | ons)                           |  | 0   |                                      |
| 50. 00                               | Pass through costs applicable to Program inpa  | atient routine                    | services (fro | m Wkst. D, su                  | m of Parts I and                             | 0   | 50. 00                               |
| 51. 00                               | Pass through costs applicable to Program inpa<br>and IV)   | atient ancillar                   | y services (f | rom Wkst. D,                   | sum of Parts II                              | 0   | 51. 00                               |
| 52. 00<br>53. 00                     | Total Program excludable cost (sum of lines! Total Program inpatient operating cost excluded and cost education costs (line 49 minus line!   | ding capital re                   | lated, non-ph | ysi ci an anest                | hetist, and                                  | 0   |                                      |
| 54. 00<br>55. 00                     | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge   |                                   |               |                                |  | 0.00                                      |                                      |
| 56. 00<br>57. 00                     | Target amount (line 54 x line 55) Difference between adjusted inpatient operati  | ing cost and ta                   | rget amount ( | line 56 minus                  | line 53)                                     | 0 0                                       | 56. 00                               |
| 58. 00<br>59. 00                     | Bonus payment (see instructions)<br>Lesser of lines 53/54 or 55 from the cost remarket basket  | · ·                               |               |                                | •  | 0.00                                      | 58. 00                               |
| 60. 00<br>61. 00                     | Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines which operating costs (line 53) are less than the lines of | s 55, 59 or 60<br>n expected cost | enter the Les | ser of 50% of                  | the amount by                                | 0.00                                      | 1                                    |
| 62. 00<br>63. 00                     | amount (line 56), otherwise enter zero (see i<br>Relief payment (see instructions)<br>Allowable Inpatient cost plus incentive paymo  | •                                 | ctions)       |                                |  | 0   |                                      |
| 64. 00                               | PROGRAM INPATIENT ROUTINE SWING BED COST<br>Medicare swing-bed SNF inpatient routine cos   | ts through Dece                   | mber 31 of th | e cost report                  | ing period (See                              | 0   | 64. 00                               |
| 65. 00                               | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos   | ts after Decemb                   | er 31 of the  | cost reportin                  | g period (See                                | 0   | 65. 00                               |
| 66. 00                               | <pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient roution CAH (see instructions)</pre>   | ne costs (line                    | 64 plus line  | 65)(title XVI                  | II only). For                                | 0   | 66. 00                               |
| 67. 00                               | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)  | e costs through                   | December 31   | of the cost r                  | eporting period                              | 0   | 67. 00                               |
| 68. 00                               | Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)  | e costs after D                   | ecember 31 of | the cost rep                   | orting period                                | 0   | 68. 00                               |
| 69. 00                               | Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU   |                                   |               |                                |  | 0   | 69. 00                               |
| 70. 00<br>71. 00                     | Skilled nursing facility/other nursing facili<br>Adjusted general inpatient routine service co   | ity/ICF/IID rou                   | tine service  | cost (line 37                  | ")   |   | 70. 00<br>71. 00                     |
| 72.00                                | Program routine service cost (line 9 x line  |                                   | (line 14 v l  | ino 2E)                        |  |   | 72. 00<br>73. 00                     |
| 73. 00<br>74. 00<br>75. 00           | Medically necessary private room cost applications. Total Program general inpatient routine servicapital-related cost allocated to inpatient.  | ice costs (line                   | 72 + line 73  | )                              | Part II. column                              |   | 74. 00<br>75. 00                     |
| 76. 00                               | 26, line 45)<br>Per diem capital-related costs (line 75 ÷ lin  | ne 2)                             | •             |                                |  |   | 76. 00                               |
| 77. 00<br>78. 00                     | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus   | s line 77)                        |               |                                |  |   | 77. 00<br>78. 00                     |
| 79. 00<br>80. 00                     | Aggregate charges to beneficiaries for excess Total Program routine service costs for compa  | arison to the c                   |               |                                | nus line 79)                                 |   | 79. 00<br>80. 00                     |
| 81. 00<br>82. 00                     | Inpatient routine service cost per diem limit<br>Inpatient routine service cost limitation (li   |                                   | )             |                                |  |   | 81. 00<br>82. 00                     |
| 83. 00                               | Reasonable inpatient routine service costs (   | see instruction                   | •             |                                |  |   | 83. 00                               |
| 84. 00<br>85. 00                     | Program inpatient ancillary services (see insultilization review - physician compensation  |                                   | ne)           |                                |  |   | 84. 00<br>85. 00                     |
| 86. 00                               | Total Program inpatient operating costs (sum   | of lines 83 th                    |               |                                |  |   | 86.00                                |
| 87. 00                               | PART IV - COMPUTATION OF OBSERVATION BED PASS<br>Total observation bed days (see instructions)   |                                   |               |                                |  | 808                                       | 87. 00                               |
| 88. 00<br>89. 00                     | Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see  | diem (line 27 ÷                   | line 2)       |                                |  | 2, 083. 03<br>1, 683, 088                 | 88. 00                               |

| Health Financial Systems                    | IU HEALTH WHI | TE HOSPITAL    |            | In Lie                           | u of Form CMS-2                  | 2552-10 |
|---|---------------|----------------|------------|----------------------------------|----------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |               | Provi der CO   |            | Peri od:                         | Worksheet D-1                    |         |
|   |               |                |            | From 01/01/2017<br>To 12/31/2017 | Date/Time Prep<br>5/25/2018 5:20 |         |
|   |               | Titl           | e XIX      | Hospi tal                        | Cost                             |         |
| Cost Center Description                     | Cost          | Routine Cost   | column 1 ÷ | Total                            | Observation                      |         |
|   |               | (from line 21) | column 2   | Observati on                     | Bed Pass                         |         |
|   |               |                |            | Bed Cost (from                   | Through Cost                     |         |
|   |               |                |            | line 89)                         | (col. 3 x col.                   |         |
|   |               |                |            |                                  | 4) (see                          |         |
|   |               |                |            |                                  | instructions)                    |         |
|   | 1.00          | 2.00           | 3. 00      | 4. 00                            | 5. 00                            |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST          |                |            |                                  |                                  |         |
| 90.00 Capital -related cost                 | 1, 018, 280   | 5, 494, 853    | 0. 18531   | 5 1, 683, 088                    | 311, 901                         | 90.00   |
| 91.00 Nursing School cost                   | 0             | 5, 494, 853    | 0.00000    | 1, 683, 088                      | 0                                | 91.00   |
| 92.00 Allied health cost                    | 0             | 5, 494, 853    | 0.00000    | 1, 683, 088                      | 0                                | 92.00   |
| 93.00 All other Medical Education           | 0             | 5, 494, 853    | 0. 00000   | 1, 683, 088                      | 0                                | 93. 00  |

| <u> </u>   | HEALTH WHITE HOSPITAL |                      |                                  | eu of Form CMS-2 |        |
|--|-----------------------|----------------------|----------------------------------|------------------|--------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT   | Provider CC           |                      | Peri od:                         | Worksheet D-3    |        |
|  |                       |                      | From 01/01/2017<br>To 12/31/2017 | Date/Time Pre    | pared: |
|  |                       |                      |                                  | 5/25/2018 5:2    |        |
|  | Title                 | XVIII                | Hospi tal                        | Cost             |        |
| Cost Center Description  |                       | Ratio of Cos         |                                  | Inpati ent       |        |
|  |                       | To Charges           | Program                          | Program Costs    |        |
|  |                       |                      | Charges                          | (col. 1 x col.   |        |
|  |                       | 1.00                 | 2.00                             | 2)<br>3. 00      |        |
| INPATIENT ROUTINE SERVICE COST CENTERS   |                       | 1.00                 | 2.00                             | 3.00             |        |
| 30. 00 03000 ADULTS & PEDIATRICS   |                       |                      | 1, 557, 251                      |                  | 30.00  |
| 31. 00   03100   NTENSI VE CARE UNI T  |                       |                      | 0                                |                  | 31.00  |
| 43. 00   04300   NURSERY   |                       |                      |                                  |                  | 43.00  |
| ANCI LLARY SERVI CE COST CENTERS   |                       |                      |                                  | '                |        |
| 50. 00 05000 OPERATI NG ROOM   |                       | 0. 35529             | 96 19, 566                       | 6, 952           | 50.00  |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM   |                       | 0. 00000             | 0 0                              | 0                | 52.00  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   |                       | 0. 20656             | 27, 311                          | 5, 641           | 54.00  |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C   |                       | 0. 21619             | 0 8                              | 0                |        |
| 56. 00   03630   ULTRA SOUND   |                       | 0. 13209             |                                  |                  |        |
| 57. 00   05700   CT   SCAN   |                       | 0. 13469             |                                  |                  |        |
| 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)   |                       | 0. 23361             |                                  |                  |        |
| 60. 00   06000   LABORATORY  |                       | 0. 27296             |                                  |                  |        |
| 66. 00   06600   PHYSI CAL THERAPY   |                       | 0. 50584             |                                  |                  |        |
| 67. 00 06700 OCCUPATI ONAL THERAPY   |                       | 0. 62821             |                                  |                  |        |
| 68. 00 06800 SPEECH PATHOLOGY  |                       | 0. 68695             |                                  |                  |        |
| 69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS |                       | 0. 08082             |                                  |                  |        |
| 72.00 07200 MPL. DEV. CHARGED TO PATIENTS  |                       | 0. 34877<br>0. 13017 |                                  | 1, 688<br>0      | 72.00  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS   |                       | 0. 13017             |                                  | _                |        |
| 73. 01 07301 DNCOLOGY DRUGS  |                       | 0. 11455             |                                  | 104, 047         | 73.00  |
| 76. 00   03020   CARDI OPULMONARY  |                       | 0. 87473             |                                  | _                |        |
| OUTPATIENT SERVICE COST CENTERS  |                       | 0.07475              | 170, 220                         | 171,047          | 70.00  |
| 90. 00   09000   CLINIC  |                       | 0. 43872             | 19 0                             | 0                | 90.00  |
| 91. 00   09100   EMERGENCY   |                       | 0. 26823             |                                  | _                |        |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  |                       | 0. 36664             |                                  |                  |        |
| 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)  |                       | 0.00000              |                                  | l                | 1      |
| 200,00 Total (sum of lines 50 through 94 and 96 th   | rough 98)             |                      | 2, 035, 776                      | 538 160          | 200 00 |

91.00 O9100 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
92.01 O9201 OBSERVATION BEDS (DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 Net charges (line 200 minus line 201)

538, 160 200. 00 201. 00 202. 00

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|---|----------------------------|----------------------|----------------------------|------------------|------------------|
| Health Financial Systems  | IU HEALTH WHITE HOSPITAL   | N 15 1010            |                            | eu of Form CMS-2 | 2552-10          |
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                                  | Provi der CC               |                      | Period:<br>From 01/01/2017 | Worksheet D-3    |                  |
|   | Component (                |                      | To 12/31/2017              |                  | oared:           |
|   | ·                          |                      |                            | 5/25/2018 5: 20  |                  |
|   |                            |                      | Swing Beds - SNF           |                  |                  |
| Cost Center Description   |                            | Ratio of Cost        |                            | Inpati ent       |                  |
|   |                            | To Charges           | Program                    | Program Costs    |                  |
|   |                            |                      | Charges                    | (col. 1 x col.   |                  |
|   |                            | 1.00                 | 0.00                       | 2)               |                  |
| LUBATI ENT. DOUTLING OFFINI OF COOT OFFITEDO                                    |                            | 1. 00                | 2. 00                      | 3. 00            |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS  |                            |                      |                            |                  |                  |
| 30. 00   03000   ADULTS & PEDI ATRI CS  |                            |                      | 0                          |                  | 30.00            |
| 31. 00   03100   INTENSIVE CARE UNIT  |                            |                      | 0                          |                  | 31. 00           |
| 43. 00 04300 NURSERY  |                            |                      |                            |                  | 43.00            |
| ANCILLARY SERVICE COST CENTERS  |                            | 0.05500              |                            |                  | F0 00            |
| 50. 00 05000 OPERATING ROOM   |                            | 0. 35529             |                            | 0                | 50.00            |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM   |                            | 0.00000              |                            | 0                | 52. 00           |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  |                            | 0. 20656             |                            |                  |                  |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C  |                            | 0. 21619             |                            | 0                | 55. 00           |
| 56. 00   03630   ULTRA SOUND  |                            | 0. 13209             | •                          |                  | 56. 00           |
| 57. 00 05700 CT SCAN  |                            | 0. 13469             |                            |                  | 57.00            |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)<br>60.00   06000   LABORATORY |                            | 0. 23361<br>0. 27296 |                            |                  | 58.00            |
| 60. 00   06000   LABORATORY<br>66. 00   06600   PHYSI CAL THERAPY               |                            |                      |                            |                  | 60. 00<br>66. 00 |
| 67. 00   06700   OCCUPATIONAL THERAPY   |                            | 0. 50584<br>0. 62821 |                            |                  | 67. 00           |
| 68. 00 06800 SPEECH PATHOLOGY   |                            | 0. 62821             | •                          |                  | 68. 00           |
| 69. 00   06900   ELECTROCARDI OLOGY   |                            | 0. 08082             | •                          |                  | 69.00            |
| 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS                           |                            | 0. 08082             |                            |                  | 71. 00           |
| 72. 00 07700 MEDICAL SUPPLIES CHARGED TO PATIENTS                               |                            | 0. 34877             |                            | 1                | 71.00            |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  |                            | 0. 13017             |                            | 1 "              | 72.00            |
| 73. 00   07300   DRUGS CHARGED TO PATTENTS  73. 01   07301   ONCOLOGY DRUGS     |                            | 0. 11955             |                            | 25, 0/1          | 73.00            |
| 73. 01   07301   0NCOLOGY DRUGS<br>76. 00   03020   CARDI OPULMONARY            |                            | 0. 87473             |                            | 1                | 76. 00           |
| OUTPATIENT SERVICE COST CENTERS   |                            | 0.87473              | <u>၁</u>   15, U15         | 13, 134          | 70.00            |
| on on honor clinic  |                            | 0.43972              | al o                       |                  | on nn            |

0. 438729

0. 268232

0. 366641

0.000000

0 90.00

0 92. 01

164, 424 200. 00

91.00 0

92.00

201. 00

202. 00

0

489, 493

489, 493

90.00

202.00

09000 CLI NI C

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

92.00 | 09200 | 085ERVATION BEDS (NON-DISTINCT FART)
92.01 | 09201 | 085ERVATION BEDS (DISTINCT PART)
200.00 | Total (sum of lines 50 through 94 and 96 through 98)
201.00 | Less PPP Clinic Laboratory Services-Program only charges (line 61)

91. 00 09100 EMERGENCY

| Health Financial S      |   | IU HEALTH WHITE HOSPITAL |              |                                       | eu of Form CMS- |        |
|-------------------------|---|--------------------------|--------------|---------------------------------------|-----------------|--------|
| INPATIENT ANCILLAR      | Y SERVICE COST APPORTIONMENT            | Provi der (              |              | Peri od:<br>From 01/01/2017           | Worksheet D-3   |        |
|                         |   |                          |              | To 12/31/2017                         |                 | pared: |
|                         |   |                          |              |                                       | 5/25/2018 5: 2  |        |
|                         |   | Ti t                     | le XIX       | Hospi tal                             | Cost            |        |
| Cost C                  | Center Description                      |                          | Ratio of Cos |                                       | I npati ent     |        |
|                         |   |                          | To Charges   | Program                               | Program Costs   |        |
|                         |   |                          |              | Charges                               | (col. 1 x col.  |        |
|                         |   |                          |              |                                       | 2)              |        |
| LUBATI ENT. DO          | NUTLINE OFFICE OF SOUT OFFITTEDS        |                          | 1.00         | 2. 00                                 | 3. 00           |        |
|                         | OUTINE SERVICE COST CENTERS             |                          |              |                                       |                 | 00.00  |
|                         | S & PEDIATRICS                          |                          |              | 0                                     |                 | 30.00  |
|                         | SIVE CARE UNIT                          |                          |              | 0                                     |                 | 31.00  |
| 43. 00 04300 NURSEF     |   |                          |              | 0                                     |                 | 43. 00 |
|                         | ERVI CE COST CENTERS                    |                          | 0.25520      | · · · · · · · · · · · · · · · · · · · | 1 0             | F0 00  |
| 50. 00 05000 OPERAT     |   |                          | 0. 35529     |                                       | 1               | 50.00  |
|                         | ERY ROOM & LABOR ROOM                   |                          | 0.00000      |                                       | 0               | 52.00  |
|                         | LOGY - DI AGNOSTI C                     |                          | 0. 20656     |                                       | 0               | 54.00  |
|                         | LOGY-THERAPEUTI C                       |                          | 0. 21619     |                                       | 0               | 55.00  |
| 56. 00 03630 ULTRA      |   |                          | 0. 13209     |                                       | 0               | 56.00  |
| 57. 00   05700 CT SCA   |   |                          | 0. 13469     |                                       | 0               | 57. 00 |
|                         | TIC RESONANCE IMAGING (MRI)             |                          | 0. 23361     |                                       | 0               | 58. 00 |
| 60. 00 06000 LABORA     |   |                          | 0. 27296     |                                       | 0               | 60.00  |
| 66. 00 06600 PHYSI 0    |   |                          | 0. 50584     |                                       | 0               | 66.00  |
|                         | ATI ONAL THERAPY                        |                          | 0. 62821     |                                       | 0               | 67.00  |
| 68. 00 06800 SPEECH     |   |                          | 0. 68695     |                                       | 0               | 68.00  |
| 69. 00 06900 ELECTF     |   |                          | 0. 08082     |                                       | 0               | 69.00  |
|                         | AL SUPPLIES CHARGED TO PATIENTS         |                          | 0. 34877     |                                       | 0               | 71.00  |
|                         | DEV. CHARGED TO PATIENTS                |                          | 0. 13017     |                                       | 0               | 72.00  |
|                         | CHARGED TO PATIENTS                     |                          | 0. 11955     |                                       | 0               | 73. 00 |
| 73. 01   07301   0NCOLO |   |                          | 0. 61364     |                                       | 0               | 73. 01 |
| 76. 00 03020 CARDI 0    |   |                          | 0. 87473     | 33  0                                 | 0               | 76. 00 |
|                         | SERVICE COST CENTERS                    |                          |              |                                       |                 |        |
| 90. 00 09000 CLI NI 0   |   |                          | 0. 43872     |                                       | -               |        |
| 91. 00 09100 EMERGE     | :NCY<br>/ATION DEDS (NON DISTINCT DADT) |                          | 0. 26823     |                                       | 0               |        |
| as un inasuni arceri    | (ATION BEDS (NON_DISTINCT DART)         |                          | 0 2666/      | 11                                    | Λ               | 1 02 0 |

0. 438729 0. 268232 0. 366641

0.000000

90. 00 91. 00 92. 00 0

0 92.01 0 200.00 201.00 202.00

0

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

92.01 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201 | 09201

| No.  |        |   |                           | 10 12/31/201/  | Date/lime Pre<br>5/25/2018 5:2 |        |
|--|--------|---|---------------------------|----------------|--------------------------------|--------|
| Note      |        |   | Title XVIII               | Hospi tal      |                                | Орш    |
| Note      |        |   |                           |                |                                |        |
| Medical and other services (see instructions)  |        |   |                           |                | 1. 00                          |        |
| New York    |        |   |                           |                |                                |        |
| 0   00   00   00   00   00   00   00   |        | ,   |                           |                |                                |        |
| 0.011   or   payment (see instructions)  |        | ,   | tions)                    |                |                                | •      |
| 0.011   cr   reconcilitation arount (see instructions)   |        | 1 . 3   |                           |                |                                |        |
| Enter the hoop Ital specific payment to cost ratio (see instructions)   0.000   5.   |        |   |                           |                |                                |        |
| Une 2 times   Ine 5  |        | 1   | ctions)                   |                |                                |        |
| Sam of Tines 3, 4, and 4,01, divided by line 6   0.00   7.   |        |   | ,                         |                |                                | •      |
| Ancillary service other pass through costs from Wist. D, Pt. IV, col. 13, line 200   0   9,  | 7.00   |   |                           |                | 0.00                           | 7. 00  |
| 10.00   Organ acquisitions   7,562,411     | 8.00   | Transitional corridor payment (see instructions)                |                           |                | 0                              | 8.00   |
| 1.1.0   Total cost (sum of lines 1 and 10) (see instructions)   7, 562, 411  | 9.00   |   | IV, col. 13, line 200     |                | -                              |        |
| COMPUTATION OF LESSER OF COST OR CHÂRGES   |        |   |                           |                |                                |        |
| Reasonable charges   12.00   Ancil Tarry service charges   0   12.10   Ancil Tarry service charges   0   13.10   0   13.11   10.10   10.11   10.10   10.11   10.10   10.11   10.10     | 11. 00 |   |                           |                | 7, 562, 411                    | 11.00  |
| 12.00   Ancil lary service charges   0   12.   |        |   |                           |                |                                | 1      |
| 13.00   Organ acquisition charges (from Wist. D-4, Pt. III. col. 4, Iine 69)   0   14.   | 12 00  |   |                           |                |                                | 12 00  |
| 14.00  |        |   | ine 60)                   |                |                                |        |
| Customary charges  |        |   | 1116 07)                  |                |                                |        |
| 15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.  | 11.00  |   |                           |                |                                | 1 00   |
| 16.00   Amounts that would have been real ized from patients I iable for payment for services on a chargebasis had but hayment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.0000000   17.0000000   17.0000000   17.0000000   17.0000000   17.0000000   17.00000000   17.00000000   17.00000000   17.000000000   17.00000000   17.000000000   17.000000000   17.000000000000000000000000000000000000   | 15.00  |   | payment for services on   | a charge basis | 0                              | 15.00  |
| 17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.   | 16.00  |   |                           |                | 0                              | 16.00  |
| 19.00   Total customary charges (see instructions)   0   18.   |        | had such payment been made in accordance with 42 CFR §413.13(   | e)                        |                |                                |        |
| 19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   19.1  |        |   |                           |                |                                |        |
| Instructions    2  |        |   |                           | 443. (         |                                |        |
| 20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.   | 19. 00 |   | ly if line 18 exceeds li  | ne 11) (see    | 0                              | 19.00  |
| Instructions   | 20.00  |   | ly if line 11 eyecods li  | no 10) (coo    | _                              | 20.00  |
| 21.00   Lesser of cost or charges (see instructions)   7, 638, 352   21.   | 20.00  |   | Ty IT TITLE IT exceeds IT | ne ro) (see    | U                              | 20.00  |
| 22.00   Interns and residents (see instructions)   0   22.   | 21. 00 |   |                           |                | 7. 638. 035                    | 21.00  |
| 24.   24.   25.   24.   25.   24.   25.   25.   25.   25.   26.    |        | ,   |                           |                |                                |        |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   Deductibles and coinsurance (for CAH, see instructions)   4,570,722   26.1   25.00   Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)   4,570,722   26.1   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0,28.1   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0 29.1   29.00   ESPG direct medical education costs (from Wkst. E-4, line 50)   0 29.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   29.00   Subtotal (sum of lines 27 through 29)   3,001,482   30.1   20.00   Subtotal (see instructions)   3,001,482   30.1   20.00   Allowable bad debts (see instructions)   650,702   34.1   20.01   Allowable bad debts (see instructions)   454,233   36.1   20.02   Allowable bad debts for dual eligible beneficiaries (see instructions)   3,424,287   37.1   20.01   Allowable bad debts for dual eligible beneficiaries (see instructions)   39.1   20.01   Allowable bad debts for dual eligible beneficiaries (see instructions)   39.1   20.01   Allowable bad debts for dual eligible beneficiaries (see instructions)   39.1   20.01   Allowable bad debts for dual eligible beneficiaries (see instructions)   39.1   20.01   Allowable bad debts for dual eligible beneficiaries (see instructions)   39.1   20.01   Allowable bad debts for dual eligible beneficiaries (see instructions)   39.1   20.01   Allowable bad debts for   | 23.00  | Cost of physicians' services in a teaching hospital (see instr  | ructions)                 |                | 0                              | 23.00  |
| 25.00   Deductibles and Coinsurance (for CAH, see instructions)   65,831   25.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   4,570,722   26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   4,570,722   26.00   Deductibles and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.00   Direct graduate medical education costs (from Wkst. E-4, line 36)   0   29.00   Distructions   0   29.00   Distruct    | 24. 00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)    |                           |                | 0                              | 24.00  |
| 26. 00         Deductible and Coinsurance relating to amount on line 24 (for CAH, see instructions)         4,570,722         26. 27. 00           27. 00         Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)         3,001,482         27. 0           28. 00         Direct graduate medical education payments (from Wkst. E-4, line 36)         0         28. 0           30. 00         Subtotal (sum of lines 27 through 29)         3,001,482         3,001,482         30. 0           30. 10. 00         Primary payer payments         151 31. 31. 3. 0         3,001,331         32. 0           32. 00         Subtotal (line 30 minus line 31)         3,001,331         32. 0           33. 00         Composite rate ESRD (from Wkst. I-5, line 11)         650,702         33. 0           34. 00         Allowable Bad bebts (see instructions)         452,956         35. 3           35. 00         Allowable bad debts (see instructions)         454,233         36. 00           36. 00         Allowable bad debts for dual eligible beneficiaries (see instructions)         454,233         37. 0           38. 00         MSP-LCC reconciliation amount from PS&         3,242,87         37. 3           39. 99         Pioneer ACO demonstration payment adjustment (see instructions)         39. 39. 99           39. 98   |        |   |                           |                |                                | 1      |
| 27.0   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   1  |        |   |                           |                |                                | 1      |
| Instructions   |        |   |                           | 221 /          |                                |        |
| 28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   Capp.   SERD direct medical education costs (from Wkst. E-4, line 36)   Capp.   | 27.00  | - · · · · · · · · · · · · · · · · · · ·                         | prus the sum of filles 22 | and 23] (See   | 3,001,482                      | 27.00  |
| 29. 00       ESRD direct medical education costs (from Wkst. E-4, line 36)       3, 02, 29, 30, 30, 30, 482, 30.         31. 00       Subtotal (sum of lines 27 through 29)       3, 001, 482, 30.         31. 00       Primary payer payments       151, 31, 33, 001, 381, 32.         32. 00       All owable I BaD DERIS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         33. 00       Composite rate ESRD (from Wkst. I-5, line 11)       650, 702, 34.         34. 00       All owable bad debts (see instructions)       422, 956, 35.         35. 00       All owable bad debts for dual eligible beneficiaries (see instructions)       452, 295, 35.         36. 00       All owable bad debts for dual eligible beneficiaries (see instructions)       3, 424, 287, 37.         38. 00       MSP-LCC reconciliation amount from PS&R       0         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         39. 99       Ponoer-ACO demonstration payment adjustment (see instructions)       39.         39. 99       Partial or full credits received from manufacturers for replaced devices (see instructions)       39.         40. 01       Sequestration adjustment amount after sequestration       3, 424, 287, 40.         40. 02       Demonstration payment adjustment amount after sequestration       3, 424, 287, 40.         40. 02       Demonstration payment for contractors use only)  | 28 00  |   | ine 50)                   |                | 0                              | 28 00  |
| 30. 00   Subtotal (sum of lines 27 through 29)   3.,001, 482   30.   |        |   |                           |                |                                |        |
| 32.00   Subtoral (Ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.40, and lowable bad debts (see instructions)   422.956   35.00   All lowable bad debts (see instructions)   454.233   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   454.233   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   454.233   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   34.24, 287   37.01   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   0   0   0   0   0   0   0   0   0  |        |   |                           |                | 3, 001, 482                    |        |
| ALLOWABLE   BAD   DEBTS   (EXCLUDE   BAD   DEBTS   FOR   PROFESSIONAL   SERVICES)   33. 00   Composite rate   ESRD   (from   Wist.   1.5,   line   11)   0. 33. 4. 00   Allowable   bad   debts   (see instructions)   650, 702   34. 03. 04. 00   Allowable   bad   debts   (see instructions)   422, 956   35. 03. 00   Allowable   bad   debts   for   dual   eligible   beneficiaries   (see instructions)   454, 233   36. 03. 03. 04. 05. 04. 06. 05. 07. 07. 07. 07. 07. 07. 07. 07. 07. 07   | 31.00  | Primary payer payments  |                           |                | 151                            | 31.00  |
| 33.00   Composite rate ESRD (from Wkst. I-5, line 11)  | 32.00  |   |                           |                | 3, 001, 331                    | 32.00  |
| 34.00       Allowable bad debts (see instructions)       650,702       34.05         35.00       Adjusted reimbursable bad debts (see instructions)       422,956       35.05         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       35.00       35.00         37.00       Subtotal (see instructions)       344,287       37.00         38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       38.00         39.01       Piloneer ACO demonstration payment adjustment (see instructions)       0       39.00         39.99       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.00         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.00         40.01       Sequestration adjustment (see instructions)       3, 424,287       40.00         40.01       Sequestration adjustment amount after sequestration       0       40.01         41.00       Interim payments       3, 183,131       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Bal ance due provider/program (see instructions)       0       40.01  |        |   | CES)                      |                |                                |        |
| 35.00   Adjusted reimbursable bad debts (see instructions)   422,956   35.03   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   454,233   36.01   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0.03   38.00   MSP-LCC reconciliation amount from PS&R   0.03   38.00   0.00      |        | 1   |                           |                |                                |        |
| 36.00  |        |   |                           |                |                                |        |
| 37.00   Subtotal (see instructions)   3,424,287   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   38.00   39.00    |        | ,                         | ructions)                 |                |                                |        |
| 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 253, 722 \$115.2 TO BE COMPLETED BY CONTRACTOR 44.00 Original outlier amount (see instructions) 45.00 Outlier reconciliation adjustment amount (see instructions) 46.01 Outlier reconciliation adjustment amount (see instructions) 47.00 Outlier reconciliation adjustment amount (see instructions) 48.00 Time Value of Money (see instructions) 49.00 Time Value of Money (see instructions)  |        |   | ructions)                 |                |                                |        |
| 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 39.40 Sequestration adjustment (see instructions) 39.90 Sequestration adjustment amount after sequestration 39.90 Sequestration adjustment amount amount after s |        |   |                           |                |                                |        |
| 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 90 Subtotal (see instructions) 39. 40. 00 Subtotal (see instructions) 39. 40. 01 Sequestration adjustment (see instructions) 39. 40. 01 Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payments 40. 00 Interim payments 40. 00 Tentative settlement (for contractors use only) 41. 00 Bal ance due provider/program (see instructions) 42. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 253, 722 (44.6 pt.) 41. 00 Original outlier amount (see instructions) 42. 00 Outlier reconciliation adjustment amount (see instructions) 44. 00 Outlier reconciliation adjustment amount (see instructions) 44. 00 Outlier reconciliation adjustment amount (see instructions) 44. 00 Time Value of Money (see instructions) 45. 00 Time Value of Money (see instructions) 46. 47. 48. 49. 49. 40. 40. 40. 40. 40. 40. 40. 40. 40. 40   | 39. 00 |   |                           |                |                                |        |
| 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  30. 424, 287 40. 40. 40. 40. 40. 40. 40. 40. 40. 40.  | 39. 50 |   | s)                        |                |                                | 39. 50 |
| 39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 00   40. 00   5   5   5   5   5   5   5   5   5  | 39. 97 | Demonstration payment adjustment amount before sequestration    |                           |                | 0                              | 39. 9  |
| 40.00       Subtotal (see instructions)       3, 424, 287       40. 40. 40. 40. 40. 40. 40. 40. 40. 40.  | 39. 98 | Partial or full credits received from manufacturers for replace | ced devices (see instruc  | tions)         | 0                              | 39. 98 |
| 40.01       Sequestration adjustment (see instructions)       68,486       40.0         40.02       Demonstration payment adjustment amount after sequestration       0 40.0         41.00       Interim payments       3,183,131       41.0         42.00       Tentative settlement (for contractors use only)       0 42.0         43.00       Bal ance due provider/program (see instructions)       172,670       43.0         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$253,722       253,722       44.0         90.00       Original outlier amount (see instructions)       0 90.0       90.0         91.00       Outlier reconciliation adjustment amount (see instructions)       0 91.0         92.00       The rate used to calculate the Time Value of Money       0.00       92.0         93.00       Time Value of Money (see instructions)       0 93.0  |        |   |                           |                |                                |        |
| 40.02       Demonstration payment adjustment amount after sequestration       0       40.04         41.00       Interim payments       3,183,131       41.0         42.00       Tentative settlement (for contractors use only)       0       42.0         43.00       Bal ance due provider/program (see instructions)       172,670       43.0         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$253,722       44.0         90.00       Original outlier amount (see instructions)       0       90.0         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.0         92.00       The rate used to calculate the Time Value of Money       0.00       92.0         93.00       Time Value of Money (see instructions)       0       93.0  |        |   |                           |                |                                | •      |
| 41.00 Interim payments  Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 253, 722 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 253, 722 44.00 Protested amounts (see instructions)  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  |        |   |                           |                |                                | •      |
| 42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 253, 722 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  |        | 1   |                           |                |                                |        |
| 43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 253,722 44.0    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)   |        | 1   |                           |                |                                | •      |
| 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5115.2}{5115.2}\$  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Original outlier amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Original outlier amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Original outlier amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Original outlier amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Original outlier amount (see instructions)  |        | ,   |                           |                |                                |        |
| \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions)  |        |   | nce with CMS Pub. 15-2    | chapter 1.     | '                              |        |
| TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)   | 00     | ,                         |                           | <b>p.</b>      | 200, 722                       |        |
| 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 91.00 92.00 93.00 Time Value of Money (see instructions) 90.00 91.00 91.00 92.00 93.00  |        |   |                           |                |                                | 1      |
| 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00   | 90.00  |   |                           |                | 0                              | 90.0   |
| 93.00 Time Value of Money (see instructions)   | 91. 00 | ,   |                           |                |                                |        |
|  |        | 1   |                           |                |                                | 1      |
| 94.00   Total (sum of lines 91 and 93)   0   94.0  |        |   |                           |                |                                |        |
|  | 94.00  | IOTAI (SUM OF LINES 91 and 93)                                  |                           |                | 0                              | 94.0   |

|       |  | I npati en | t Part A        | Par        | t B         |       |
|-------|--|------------|-----------------|------------|-------------|-------|
|       |  | mm/dd/yyyy | Amount          | mm/dd/yyyy | Amount      |       |
|       |  | 1.00       | 2. 00           | 3. 00      | 4.00        |       |
| 1. 00 | Total interim payments paid to provider                  |            | 1, 986, 267     |            | 3, 183, 131 | 1. 00 |
| 2.00  | Interim payments payable on individual bills, either     |            | 0               |            | 0           | 2. 00 |
|       | submitted or to be submitted to the contractor for       |            |                 |            |             |       |
|       | services rendered in the cost reporting period. If none, |            |                 |            |             |       |
|       | write "NONE" or enter a zero                             |            |                 |            |             |       |
| 3.00  | List separately each retroactive lump sum adjustment     |            |                 |            |             | 3.00  |
|       | amount based on subsequent revision of the interim rate  |            |                 |            |             |       |
|       | for the cost reporting period. Also show date of each    |            |                 |            |             |       |
|       | payment. If none, write "NONE" or enter a zero. (1)      |            |                 |            |             |       |
|       | Program to Provider                                      |            |                 |            |             |       |
| 3. 01 | ADJUSTMENTS TO PROVIDER                                  |            | 0               |            | 0           | 3. 01 |
| 3.02  |  |            | 0               |            | 0           | 3. 02 |
| 3.03  |  |            | 0               |            | 0           | 3. 03 |
| 3.04  |  |            | 0               |            | 0           | 3.04  |
| 3.05  |  |            | 0               |            | 0           | 3.05  |
|       | Provider to Program                                      |            |                 |            |             |       |
| 3.50  | ADJUSTMENTS TO PROGRAM                                   |            | 0               |            | 0           | 3. 50 |
| 3. 51 |  |            | 0               |            | 0           | 3. 51 |
| 3. 52 |  |            | 0               |            | 0           | 3. 52 |
| 3.53  |  |            | 0               |            | 0           | 3. 53 |
| 3.54  |  |            | 0               |            | 0           | 3. 54 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines      |            | 0               |            | 0           | 3. 99 |
|       | 3. 50-3. 98)   |            |                 |            |             |       |
| 4.00  | Total interim payments (sum of lines 1, 2, and 3.99)     |            | 1, 986, 267     |            | 3, 183, 131 | 4. 00 |
|       | (transfer to Wkst. E or Wkst. E-3, line and column as    |            |                 |            |             |       |
|       | appropri ate)  |            |                 |            |             |       |
| г оо  | TO BE COMPLETED BY CONTRACTOR                            | 1          |                 |            |             | г оо  |
| 5.00  | List separately each tentative settlement payment after  |            |                 |            |             | 5. 00 |
|       | desk review. Also show date of each payment. If none,    |            |                 |            |             |       |
|       | write "NONE" or enter a zero. (1) Program to Provider    | 1          |                 |            |             |       |
| 5. 01 | TENTATI VE TO PROVI DER                                  | I          | 0               |            | 0           | 5. 01 |
| 5. 01 | TENTATIVE TO PROVIDER                                    | }          | 0               |            |             | 5. 02 |
| 5. 02 |  |            | 0               |            |             | 5. 02 |
| 5.05  | Provider to Program                                      |            | U               |            | 0           | 5.03  |
| 5. 50 | TENTATI VE TO PROGRAM                                    |            | 0               |            | 0           | 5. 50 |
| 5. 51 | TENTATI VE TO TROOKAW                                    |            | o o             |            |             | 5. 51 |
| 5. 52 |  |            | o o             |            |             | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines      |            | 0               |            |             | 5. 99 |
| 5. 77 | 5. 50-5. 98)   |            |                 |            | Ĭ           | 5. 77 |
| 6.00  | Determined net settlement amount (balance due) based on  |            |                 |            |             | 6. 00 |
| 5. 00 | the cost report. (1)                                     |            |                 |            |             | 5. 00 |
| 6. 01 | SETTLEMENT TO PROVIDER                                   |            | 243, 568        |            | 172, 670    | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM                                    |            | 0               |            | 0           | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions)      | 1          | 2, 229, 835     |            | 3, 355, 801 | 7. 00 |
|       |  |            | , , , , , , , , | Contractor | NPR Date    |       |
|       |  |            |                 | Number     | (Mo/Day/Yr) |       |
|       |  | (          | )               | 1. 00      | 2.00        |       |
| 8.00  | Name of Contractor                                       |            |                 |            |             | 8. 00 |
|       |  | •          |                 |            | •           |       |

Health Financial Systems IU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

|                |   | Component  | CCN. 13-2312   1 | 0 12/31/2017         | 5/25/2018 5: 20         |                |
|----------------|---|------------|------------------|----------------------|-------------------------|----------------|
|                |   | Title      | XVIII S          | wing Beds - SNF      |                         |                |
|                |   | Inpatien   | it Part A        | Par                  | t B                     |                |
|                |   | mm/dd/yyyy | Amount           | mm/dd/yyyy           | Amount                  |                |
|                |   | 1.00       | 2.00             | 3. 00                | 4. 00                   |                |
| 1.00           | Total interim payments paid to provider   |            | 808, 687         | ,                    | 0                       | 1. 00          |
| 2.00           | Interim payments payable on individual bills, either                                    |            | (                |                      | 0                       | 2.00           |
|                | submitted or to be submitted to the contractor for                                      |            |                  |                      |                         |                |
|                | services rendered in the cost reporting period. If none,                                |            |                  |                      |                         |                |
|                | write "NONE" or enter a zero  |            |                  |                      |                         |                |
| 3.00           | List separately each retroactive lump sum adjustment                                    |            |                  |                      |                         | 3.00           |
|                | amount based on subsequent revision of the interim rate                                 |            |                  |                      |                         |                |
|                | for the cost reporting period. Also show date of each                                   |            |                  |                      |                         |                |
|                | payment. If none, write "NONE" or enter a zero. (1)                                     |            |                  |                      |                         | ļ              |
| 0.01           | Program to Provider   |            |                  | <u> </u>             |                         |                |
| 3. 01          | ADJUSTMENTS TO PROVIDER   |            | (                |                      | 0                       | 3. 01<br>3. 02 |
| 3. 02          |   |            | (                |                      | 0                       | 3.02           |
| 3.03           |   |            |                  |                      |                         |                |
| 3. 04<br>3. 05 |   |            | (                |                      | 0                       | 3. 04          |
| 3.05           | Provider to Program   |            |                  | )                    | 0                       | 3. 05          |
| 3.50           | ADJUSTMENTS TO PROGRAM  |            |                  |                      | 0                       | 3.50           |
| 3. 51          | 765 THENTO TO TROOM III   |            |                  |                      |                         | 3. 51          |
| 3. 52          |   |            |                  |                      | Ö                       | 3. 52          |
| 3. 53          |   |            |                  |                      | Ö                       | 3. 53          |
| 3.54           |   |            |                  |                      | O                       | 3. 54          |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines                                     |            | (                |                      | 0                       | 3. 99          |
|                | 3. 50-3. 98)  |            |                  |                      |                         |                |
| 4.00           | Total interim payments (sum of lines 1, 2, and 3.99)                                    |            | 808, 687         | 7                    | 0                       | 4.00           |
|                | (transfer to Wkst. E or Wkst. E-3, line and column as                                   |            |                  |                      |                         |                |
|                | appropri ate)   |            |                  |                      |                         |                |
|                | TO BE COMPLETED BY CONTRACTOR   | T          | T                |                      | I                       |                |
| 5.00           | List separately each tentative settlement payment after                                 |            |                  |                      |                         | 5. 00          |
|                | desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) |            |                  |                      |                         |                |
|                | Program to Provider   |            |                  |                      |                         | -              |
| 5. 01          | TENTATI VE TO PROVI DER   |            |                  | 1                    | 0                       | 5. 01          |
| 5. 02          | TENTATIVE TO TROVIDER   |            |                  |                      | ا                       | 5. 02          |
| 5. 03          |   |            |                  |                      | 0                       | 5. 03          |
|                | Provider to Program   | L          |                  | -1                   |                         |                |
| 5.50           | TENTATI VE TO PROGRAM   |            | (                | )                    | 0                       | 5. 50          |
| 5. 51          |   |            |                  |                      | 0                       | 5. 51          |
| 5.52           |   |            | (                |                      | 0                       | 5. 52          |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines                                     |            | (                | )                    | 0                       | 5. 99          |
|                | 5. 50-5. 98)  |            |                  |                      |                         |                |
| 6.00           | Determined net settlement amount (balance due) based on                                 |            |                  |                      |                         | 6. 00          |
|                | the cost report. (1)  |            |                  |                      |                         |                |
| 6. 01          | SETTLEMENT TO PROVIDER  |            | 133, 277         |                      | 0                       | 6. 01          |
| 6. 02          | SETTLEMENT TO PROGRAM   |            | (                | 1                    | 0                       | 6. 02          |
| 7. 00          | Total Medicare program liability (see instructions)                                     |            | 941, 964         |                      | 0                       | 7. 00          |
|                |   |            |                  | Contractor<br>Number | NPR Date<br>(Mo/Day/Yr) |                |
|                |   |            | <br>)            | 1. 00                | 2. 00                   |                |
| 8. 00          | Name of Contractor  |            | ~                | 1.00                 | 2.00                    | 8. 00          |
| 00             | 1   | I          |                  | I .                  | 1                       | , 0.00         |

| Heal th | Financial Systems   | IU HEALTH WHITE HOSPITAL  |                | In Lie                                       | u of Form CMS-:  | 2552-10 |
|---------|---|---------------------------|----------------|--|--|---------|
| CALCUL  | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT   | Provi del                 | CCN: 15-1312   | Peri od:<br>From 01/01/2017<br>To 12/31/2017 | Worksheet E-1<br>Part II<br>Date/Time Pre<br>5/25/2018 5:2 | pared:  |
|         |   | Ti                        | tle XVIII      | Hospi tal                                    | Cost   |         |
|         |   |                           |                |  |  |         |
|         |   |                           |                |  | 1. 00  |         |
|         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD   | COST REPORTS              |                |  |  |         |
|         | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION   | AND CALCULATION           |                |  |  |         |
| 1.00    | 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 |                           |                |  |  | 1. 00   |
| 2.00    | Medicare days from Wkst. S-3, Pt. I, col. 6 su  | um of lines 1, 8-12       |                |  |  | 2. 00   |
| 3.00    | Medicare HMO days from Wkst. S-3, Pt. I, col.   | 6. line 2                 |                |  |  | 3. 00   |
| 4.00    | Total inpatient days from S-3, Pt. I col. 8 su  | um of lines 1, 8-12       |                |  |  | 4.00    |
| 5.00    | Total hospital charges from Wkst C, Pt. I, col  | . 8 line 200              |                |  |  | 5. 00   |
| 6.00    | Total hospital charity care charges from Wkst.  |                           |                |  |  | 6. 00   |
| 7. 00   | CAH only - The reasonable cost incurred for the line 168                                      | ne purchase of certified  | HIT technology | Wkst. S-2, Pt. I                             |  | 7. 00   |
| 8.00    | Calculation of the HIT incentive payment (see   | instructions)             |                |  |  | 8. 00   |
| 9.00    | Sequestration adjustment amount (see instructi  | ons)                      |                |  |  | 9. 00   |
| 10.00   | Calculation of the HIT incentive payment after  |                           | ructions)      |  |  | 10.00   |
|         | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & (  |                           |                | '  |  | 1       |
| 30.00   | Initial/interim HIT payment adjustment (see in  |                           |                |  |  | 30.00   |
|         | Other Adjustment (specify)  |                           |                |  |  | 31. 00  |
|         | Dalance due provider (line 0 (er line 10) min   | is line 20 and line 21) ( |                | 5)   |  | 22 00   |

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

|                 |   | Component Con. 13-2312     | 10 12/31/2017      | 5/25/2018 5: 2                        |         |
|-----------------|---|----------------------------|--------------------|---------------------------------------|---------|
|                 |   | Title XVIII                | Swing Beds - SNF   |                                       |         |
|                 |   |                            | Part A             | Part B                                |         |
|                 |   |                            | 1. 00              | 2. 00                                 |         |
|                 | COMPUTATION OF NET COST OF COVERED SERVICES   |                            |                    |                                       |         |
| 1.00            | Inpatient routine services - swing bed-SNF (see instructions)                             |                            | 803, 674           | 0                                     | 1.00    |
| 2.00            | Inpatient routine services - swing bed-NF (see instructions)                              |                            |                    |                                       | 2.00    |
| 3.00            | Ancillary services (from Wkst. D-3, col. 3, line 200, for Par                             |                            | 166, 068           | 0                                     | 3.00    |
|                 | Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in                             |                            |                    |                                       |         |
| 4.00            | Per diem cost for interns and residents not in approved teachi                            | ing program (see           |                    | 0. 00                                 | 4.00    |
|                 | instructions)   |                            |                    |                                       |         |
| 5.00            | Program days  |                            | 382                | 0                                     |         |
| 6.00            | Interns and residents not in approved teaching program (see in                            | *                          |                    | 0                                     |         |
| 7.00            | Utilization review - physician compensation - SNF optional me                             | thod only                  | 0(0.742            | 0                                     | 7.00    |
| 8.00            | Subtotal (sum of lines 1 through 3 plus lines 6 and 7)                                    |                            | 969, 742           | 0                                     |         |
| 9. 00<br>10. 00 | Primary payer payments (see instructions)   |                            | 040 743            | 0                                     |         |
|                 | Subtotal (line 8 minus line 9)  | aabla ta mbuaisian         | 969, 742           | 0                                     |         |
| 11. 00          | Deductibles billed to program patients (exclude amounts appliance) professional services) | cable to physician         | ٩                  | 0                                     | 11.00   |
| 12. 00          | Subtotal (line 10 minus line 11)  |                            | 969, 742           | 0                                     | 12. 00  |
| 13. 00          | Coinsurance billed to program patients (from provider records)                            | ) (evolude coinsurance     | 8, 554             | 0                                     | 1       |
| 13.00           | for physician professional services)  | (exclude collisulance      | 0, 334             | O                                     | 13.00   |
| 14.00           | 80% of Part B costs (line 12 x 80%)   |                            |                    | 0                                     | 14.00   |
| 15. 00          | Subtotal (enter the lesser of line 12 minus line 13, or line                              | 14)                        | 961, 188           | 0                                     | 1       |
| 16. 00          | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | ,                          | 701, 100           | 0                                     |         |
| 16. 50          | Pioneer ACO demonstration payment adjustment (see instructions                            | s)                         |                    | Ü                                     | 16. 50  |
| 16. 55          | Rural community hospital demonstration project (§410A Demonstr                            | •                          | 0                  |                                       | 16. 55  |
|                 | adjustment (see instructions)   | atton, paymont             | Ĭ                  |                                       | 10.00   |
| 16. 99          | Demonstration payment adjustment amount before sequestration                              |                            | o                  | 0                                     | 16. 99  |
|                 | Allowable bad debts (see instructions)  |                            | O                  | 0                                     | 1       |
|                 | Adjusted reimbursable bad debts (see instructions)  |                            | 0                  | 0                                     | 1       |
| 18.00           | Allowable bad debts for dual eligible beneficiaries (see instr                            | ructions)                  | 0                  | 0                                     | 18.00   |
| 19.00           | Total (see instructions)  |                            | 961, 188           | 0                                     | 19.00   |
| 19. 01          | Sequestration adjustment (see instructions)   |                            | 19, 224            | 0                                     | 19. 01  |
| 19. 02          | Demonstration payment adjustment amount after sequestration)                              |                            | 0                  | 0                                     | 19. 02  |
| 20.00           | Interim payments  |                            | 808, 687           | 0                                     | 20.00   |
| 21.00           | Tentative settlement (for contractor use only)  |                            | 0                  | 0                                     | 21.00   |
| 22.00           | Balance due provider/program (line 19 minus lines 19.01, 20, a                            | and 21)                    | 133, 277           | 0                                     |         |
| 23. 00          | Protested amounts (nonallowable cost report items) in accordan                            | nce with CMS Pub. 15-2,    | 32, 408            | 0                                     | 23.00   |
|                 | chapter 1, §115.2   |                            |                    |                                       |         |
|                 | Rural Community Hospital Demonstration Project (§410A Demonstr                            | ration) Adjustment         |                    |                                       |         |
| 200. 00         | Is this the first year of the current 5-year demonstration per                            | riod under the 21st        |                    |                                       | 200. 00 |
|                 | Century Cures Act? Enter "Y" for yes or "N" for no.                                       |                            |                    |                                       | -       |
| 201 00          | Cost Reimbursement  | Micat D 1 Dt II lina       |                    |                                       | 201 00  |
| 201.00          | Medicare swing-bed SNF inpatient routine service costs (from \                            | WKST. D-I, Pt. II, IINE    |                    |                                       | 201. 00 |
| 202.00          | 66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from | m Wkst D 2 col 2 lin       |                    |                                       | 202. 00 |
| 202.00          | 200 (title XVIII swing-bed SNF))  | II WKSt. D-3, COI. 3, IIII | 6                  |                                       | 202.00  |
| 203 00          | Total (sum of lines 201 and 202)  |                            |                    |                                       | 203. 00 |
|                 | Medicare swing-bed SNF discharges (see instructions)                                      |                            |                    |                                       | 204. 00 |
| 204.00          | Computation of Demonstration Target Amount Limitation (N/A in                             | first year of the curre    | nt 5-vear demonst  |                                       | 1204.00 |
|                 | period)   | Tirst year or the earre    | iri 5 year demonst | 1 4 11 011                            |         |
| 205.00          | Medicare swing-bed SNF target amount  |                            |                    |                                       | 205. 00 |
|                 | Medicare swing-bed SNF inpatient routine cost cap (line 205 ti                            | imes line 204)             |                    |                                       | 206.00  |
|                 | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs                            |                            |                    |                                       | 1       |
| 207.00          | Program reimbursement under the §410A Demonstration (see insti                            |                            |                    |                                       | 207. 00 |
|                 | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2                            |                            | 1                  |                                       | 208.00  |
|                 | and 3)  |                            |                    |                                       |         |
| 209.00          | Adjustment to Medicare swing-bed SNF PPS payments (see instruc                            | ctions)                    |                    |                                       | 209. 00 |
|                 | Reserved for future use   | •                          |                    |                                       | 210.00  |
|                 | Comparision of PPS versus Cost Reimbursement  |                            |                    |                                       |         |
| 215.00          | Total adjustment to Medicare swing-bed SNF PPS payment (line 2                            | 209 plus line 210) (see    |                    | · · · · · · · · · · · · · · · · · · · | 215. 00 |
|                 | instructions)   |                            |                    |                                       |         |
|                 |   |                            |                    |                                       |         |

| Health Financial Systems                | IU HEALTH WHITE HOSPITAL | In Lie                                       | u of Form CMS-2552-10   |
|---|--------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-1312   | Peri od:<br>From 01/01/2017<br>To 12/31/2017 | Worksheet E-3<br>Part V<br>Date/Time Prepared:<br>5/25/2018 5:20 pm |
|   | Ti +Lo Y// L L           | ⊎osni tal                                    | Cost  |

|        |   |                     |   | 5/25/2018 5: 20 | pareu.<br>O pm |
|--------|---|---------------------|---|-----------------|----------------|
|        |   | Title XVIII         | Hospi tal                               | Cost            |                |
|        |   |                     |   |                 |                |
|        |   |                     |   | 1. 00           |                |
|        | PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART  | Γ A SERVICES - COST | REIMBURSEMENT                           |                 |                |
| 1.00   | Inpati ent servi ces  |                     |   | 2, 527, 454     | 1.00           |
| 2.00   | Nursing and Allied Health Managed Care payment (see instructions)   |                     |   | 0               | 2.00           |
| 3.00   | Organ acqui si ti on  |                     |   | 0               | 3.00           |
| 4.00   | Subtotal (sum of lines 1 through 3)                                 |                     |   | 2, 527, 454     | 4.00           |
| 5.00   | Primary payer payments  |                     |   | 0               | 5.00           |
| 6.00   | Total cost (line 4 less line 5). For CAH (see instructions)         |                     |   | 2, 552, 729     | 6.00           |
|        | COMPUTATION OF LESSER OF COST OR CHARGES                            |                     | '                                       |                 | ĺ              |
|        | Reasonable charges  |                     |   |                 | İ              |
| 7.00   | Routine service charges   |                     |   | 0               | 7.00           |
| 8.00   | Ancillary service charges   |                     |   | 0               | 8.00           |
| 9. 00  | Organ acquisition charges, net of revenue                           |                     |   | 0               | 1              |
| 10.00  | Total reasonable charges  |                     |   | 0               |                |
|        | Customary charges   |                     |   | -               |                |
| 11.00  | Aggregate amount actually collected from patients liable for payme  | ent for services on | a charge basis                          | 0               | 11.00          |
| 12. 00 | Amounts that would have been realized from patients liable for par  |                     |   | 0               | 12.00          |
|        | had such payment been made in accordance with 42 CFR 413.13(e)      | ,                   |   | -               |                |
| 13.00  | Ratio of line 11 to line 12 (not to exceed 1.000000)                |                     |   | 0.000000        | 13.00          |
|        | Total customary charges (see instructions)                          |                     |   | 0               | 1              |
| 15. 00 | Excess of customary charges over reasonable cost (complete only in  | fline 14 exceeds Li | ne 6) (see                              | 0               | 15. 00         |
| .0.00  | instructions)   | e enecede           | 0) (300                                 | · ·             |                |
| 16, 00 | Excess of reasonable cost over customary charges (complete only in  | fline 6 exceeds lin | e 14) (see                              | 0               | 16.00          |
|        | instructions)   |                     | , (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                 |                |
| 17.00  | Cost of physicians' services in a teaching hospital (see instructi  | i ons)              |   | 0               | 17.00          |
|        | COMPUTATION OF REIMBURSEMENT SETTLEMENT                             |                     | ,                                       |                 | ĺ              |
| 18.00  | Direct graduate medical education payments (from Worksheet E-4, Li  | ine 49)             |   | 0               | 18.00          |
| 19.00  | Cost of covered services (sum of lines 6, 17 and 18)                | ŕ                   |   | 2, 552, 729     | 19.00          |
| 20.00  | Deductibles (exclude professional component)                        |                     |   | 293, 440        | 20.00          |
| 21.00  | Excess reasonable cost (from line 16)                               |                     |   | 0               | 21.00          |
| 22.00  | Subtotal (line 19 minus line 20 and 21)                             |                     |   | 2, 259, 289     | 22.00          |
| 23.00  | Coinsurance   |                     |   | 2, 303          | 23.00          |
| 24.00  | Subtotal (line 22 minus line 23)                                    |                     |   | 2, 256, 986     | 24.00          |
| 25.00  | Allowable bad debts (exclude bad debts for professional services)   | (see instructions)  |   | 28, 240         | 25.00          |
| 26.00  | Adjusted reimbursable bad debts (see instructions)                  | · ·                 |   | 18, 356         | 26.00          |
|        | Allowable bad debts for dual eligible beneficiaries (see instructi  | i ons)              |   | 11, 577         | 27. 00         |
|        | Subtotal (sum of lines 24 and 25, or line 26)                       | ŕ                   |   | 2, 275, 342     | 28. 00         |
|        | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                      |                     |   | 0               | l              |
| 29. 50 | Pioneer ACO demonstration payment adjustment (see instructions)     |                     |   | 0               |                |
|        | Demonstration payment adjustment amount before sequestration        |                     |   | 0               |                |
| 30.00  | Subtotal (see instructions)   |                     |   | 2, 275, 342     |                |
|        | Sequestration adjustment (see instructions)                         |                     |   | 45, 507         |                |
|        | Demonstration payment adjustment amount after sequestration         |                     |   | 0               | 1              |
|        | Interim payments  |                     |   | 1, 986, 267     |                |
|        | Tentative settlement (for contractor use only)                      |                     |   | 0               |                |
| 33. 00 | Balance due provider/program (line 30 minus lines 30.01, 30.02, 3   | 1. and 32)          |   | 243, 568        |                |
| 34. 00 | Protested amounts (nonallowable cost report items) in accordance is |                     | chapter 1.                              | 82, 284         |                |
|        | §115. 2   |                     | ' '                                     |                 |                |

Health Financial Systems IU HEALTH
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provider CCN: 15-1312 | Period: | Worksheet G | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/25/2018 5: 20 pm

| onl y)           |  |   | '                    | 0 12/31/201/   | 5/25/2018 5: 2 |                  |
|------------------|--|---|----------------------|----------------|----------------|------------------|
|                  |  | General Fund                            | Speci fi c           | Endowment Fund |                |                  |
|                  |  | 1.00                                    | Purpose Fund<br>2.00 | 3. 00          | 4. 00          |                  |
|                  | CURRENT ASSETS   | 1.00                                    | 2.00                 | 0.00           | 1. 00          |                  |
| 1.00             | Cash on hand in banks  | 24, 604, 470                            | 1                    | 0              | 0              | 1.00             |
| 2.00             | Temporary investments  | (                                       |                      | -              | 0              | 2.00             |
| 3. 00<br>4. 00   | Notes recei vabl e<br>Accounts recei vabl e  | 1, 958, 218                             |                      | 0              | 0              | 3. 00<br>4. 00   |
| 5.00             | Other receivable   | 1, 730, 210                             |                      | 0              | 0              | 5.00             |
| 6. 00            | Allowances for uncollectible notes and accounts receivable                                       | ď                                       |                      | 0              | 0              | 6. 00            |
| 7.00             | Inventory  | 244, 543                                | 3 0                  | 0              | 0              | 7. 00            |
| 8.00             | Prepaid expenses   | 124, 213                                | 3 0                  | 0              | 0              | 8. 00            |
| 9.00             | Other current assets   |   |                      | 0              | 0              | 9.00             |
| 10.00            | Due from other funds   | 24 021 444                              |                      |                | 0              | 10.00            |
| 11. 00           | Total current assets (sum of lines 1-10)  FIXED ASSETS   | 26, 931, 444                            | 4  C                 | 0              | 0              | 11. 00           |
| 12. 00           | Land   | 972, 779                                | el c                 | 0              | 0              | 12. 00           |
| 13. 00           | Land improvements  | 122, 178                                | 1                    | -              | 0              | 13. 00           |
| 14.00            | Accumulated depreciation   | -73, 430                                | o                    | 0              | 0              | 14. 00           |
| 15. 00           | Bui I di ngs   | 30, 277, 094                            | 1                    | 0              | 0              | 15. 00           |
| 16.00            | Accumulated depreciation   | -4, 960, 079                            |                      | 0              | 0              | 16.00            |
| 17. 00<br>18. 00 | Leasehold improvements Accumulated depreciation  | (                                       |                      | 0              | 0              | 17. 00<br>18. 00 |
| 19. 00           | Fi xed equipment   |   |                      | -              | 0              | 19.00            |
| 20. 00           | Accumulated depreciation   |   |                      | 0              | Ö              | 20.00            |
| 21.00            | Automobiles and trucks   |   | o o                  | 0              | 0              | 21.00            |
| 22. 00           | Accumulated depreciation   |   | 0                    | 0              | 0              | 22. 00           |
| 23. 00           | Maj or movable equipment   | 7, 549, 228                             | •                    | 0              | 0              | 23. 00           |
| 24. 00           | Accumulated depreciation   | -4, 934, 014                            |                      | 0              | 0              | 24. 00           |
| 25. 00<br>26. 00 | Minor equipment depreciable Accumulated depreciation   |   |                      | 1              | 0              | 25. 00<br>26. 00 |
| 27. 00           | HIT designated Assets  |   |                      | -              | 0              | 27.00            |
| 28. 00           | Accumul ated depreciation  | ď                                       |                      | 0              | 0              | 28. 00           |
| 29. 00           | Mi nor equi pment-nondepreci abl e   | (                                       | o                    | 0              | 0              | 29. 00           |
| 30.00            | Total fixed assets (sum of lines 12-29)  | 28, 953, 756                            | 5 0                  | 0              | 0              | 30.00            |
| 21 00            | OTHER ASSETS Investments   |   | ol c                 | O              | 0              | 31.00            |
| 31. 00<br>32. 00 | Deposits on Leases   |   |                      |                | 0              | 32.00            |
| 33. 00           | Due from owners/officers   |   |                      | -              | 0              | 33. 00           |
| 34.00            | Other assets   | 22, 385                                 | 5 C                  | 0              | 0              | 34.00            |
| 35.00            | Total other assets (sum of lines 31-34)  | 22, 385                                 |                      | 0              | 0              | 35. 00           |
| 36. 00           | Total assets (sum of lines 11, 30, and 35)   | 55, 907, 585                            | 5 <u> </u>           | 0              | 0              | 36. 00           |
| 27.00            | CURRENT LIABILITIES  | 1 141 22/                               | .1                   | O              | 0              | 27.00            |
| 37. 00<br>38. 00 | Accounts payable Salaries, wages, and fees payable   | 1, 141, 22 <i>6</i><br>859, 24 <i>6</i> | 1                    | 0              | 0              | 37. 00<br>38. 00 |
| 39. 00           | Payrol I taxes payable   | 44, 437                                 | 1                    | 0              | 0              | 39.00            |
| 40. 00           | Notes and Loans payable (short term)   | 590, 000                                |                      | 0              | 0              | 40.00            |
| 41.00            | Deferred income  | (                                       | o                    | 0              | 0              | 41.00            |
| 42.00            | Accel erated payments  | (                                       |                      |                |                | 42.00            |
| 43.00            | Due to other funds   | 4, 342, 090                             |                      | 0              | 0              | 43.00            |
| 44. 00<br>45. 00 | Other current liabilities Total current liabilities (sum of lines 37 thru 44)                    | 6, 976, 999                             | ) C                  |                | 0              |                  |
| 45.00            | LONG TERM LIABILITIES  | 0, 770, 77                              | 7                    | ı o            | 0              | 45.00            |
| 46. 00           | Mortgage payable   | (                                       | О                    | 0              | 0              | 46. 00           |
| 47.00            | Notes payable  | 20, 935, 000                            | o                    | 0              | 0              | 47. 00           |
| 48. 00           | Unsecured Loans  | (                                       | 0                    | -              | 0              | 48. 00           |
| 49. 00           | Other long term liabilities  | 387, 859                                |                      |                | 0              | 49. 00           |
| 50. 00<br>51. 00 | Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) | 21, 322, 859<br>28, 299, 858            |                      |                | 0              | 50. 00<br>51. 00 |
| 31.00            | CAPITAL ACCOUNTS   | 20, 299, 030                            | <u> </u>             | U U            | 0              | 31.00            |
| 52. 00           | General fund balance   | 27, 607, 727                            | 7                    |                |                | 52. 00           |
| 53.00            | Specific purpose fund  |   | C                    |                |                | 53. 00           |
| 54.00            | Donor created - endowment fund balance - restricted  |   |                      | 0              |                | 54. 00           |
| 55. 00           | Donor created - endowment fund balance - unrestricted  |   |                      | 0              |                | 55. 00           |
| 56. 00           | Governing body created - endowment fund balance  |   |                      | 0              | 0              | 56.00            |
| 57. 00<br>58. 00 | Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,       |   |                      |                | 0              | 57. 00<br>58. 00 |
| 50.00            | replacement, and expansion   |   |                      |                |                | 30.00            |
| 59. 00           | Total fund balances (sum of lines 52 thru 58)  | 27, 607, 727                            | 7 C                  | 0              | 0              | 59. 00           |
| 60. 00           | Total liabilities and fund balances (sum of lines 51 and   | 55, 907, 585                            | 5 0                  | 0              | 0              | 60. 00           |
|                  | [59]   | I                                       | I                    |                |                | l                |

Provider CCN: 15-1312

|                  |   |                |                       |          | То  | 12/31/2017 | Date/Time Prep<br>5/25/2018 5:20 |                  |
|------------------|---|----------------|-----------------------|----------|-----|------------|----------------------------------|------------------|
|                  |   | General        | Fund                  | Speci al | Pur | pose Fund  | Endowment Fund                   | , piii           |
|                  |   |                |                       |          |     |            |                                  |                  |
|                  |   | 1.00           | 0.00                  | 0.00     |     | 4.00       | F 00                             |                  |
| 1. 00            | Fund balances at beginning of period  | 1.00           | 2. 00<br>28, 228, 974 | 3. 00    |     | 4. 00      | 5. 00                            | 1. 00            |
| 2. 00            | Net income (loss) (from Wkst. G-3, line 29)   |                | -357, 819             |          |     | U          |                                  | 2. 00            |
| 3.00             | Total (sum of line 1 and line 2)  |                | 27, 871, 155          |          |     | 0          |                                  | 3. 00            |
| 4.00             | Additions (credit adjustments) (specify)  | 0              | 27,071,100            |          | 0   | 0          | 0                                | 4. 00            |
| 5. 00            |   | o              |                       |          | 0   |            | l ol                             | 5. 00            |
| 6.00             |   | 0              |                       |          | 0   |            | 0                                | 6.00             |
| 7.00             |   | 0              |                       |          | 0   |            | 0                                | 7.00             |
| 8.00             |   | 0              |                       |          | 0   |            | 0                                | 8.00             |
| 9.00             |   | 0              |                       |          | 0   |            | 0                                | 9.00             |
| 10. 00           | Total additions (sum of line 4-9)   |                | 0                     |          |     | 0          |                                  | 10.00            |
| 11. 00           | Subtotal (line 3 plus line 10)  |                | 27, 871, 155          |          |     | 0          |                                  | 11. 00           |
| 12.00            | Deductions (debit adjustments) (specify)  | 0              |                       |          | 0   |            | 0                                | 12.00            |
| 13.00            | NET INTERCOMPANY TRANSACTIONS   | 263, 428       |                       |          | 0   |            | 0                                | 13.00            |
| 14. 00<br>15. 00 |   | 0              |                       |          | 0   |            | 0                                | 14. 00<br>15. 00 |
| 16. 00           |   |                |                       |          | 0   |            |                                  | 16. 00           |
| 17. 00           |   |                |                       |          | 0   |            | 0                                | 17. 00           |
| 18. 00           | Total deductions (sum of lines 12-17)   |                | 263, 428              |          | J   | 0          | ١                                | 18. 00           |
| 19. 00           | Fund balance at end of period per balance   |                | 27, 607, 727          |          |     | 0          |                                  | 19. 00           |
|                  | sheet (line 11 minus line 18)   |                | ,                     |          |     |            |                                  |                  |
|                  |   | Endowment Fund | PI ant                | Fund     |     |            |                                  |                  |
|                  |   | 4.00           | 7. 00                 | 0.00     |     |            |                                  |                  |
| 1. 00            | Fund balances at beginning of period  | 6.00           | 7.00                  | 8. 00    | 0   |            |                                  | 1. 00            |
| 2.00             | Net income (loss) (from Wkst. G-3, line 29)   |                |                       |          | U   |            |                                  | 2. 00            |
| 3.00             | Total (sum of line 1 and line 2)  | 0              |                       |          | 0   |            |                                  | 3. 00            |
| 4. 00            | Additions (credit adjustments) (specify)  | ]              | 0                     |          | -   |            |                                  | 4. 00            |
| 5.00             |   |                | 0                     |          |     |            |                                  | 5. 00            |
| 6.00             |   |                | 0                     |          |     |            |                                  | 6.00             |
| 7.00             |   |                | 0                     |          |     |            |                                  | 7. 00            |
| 8.00             |   |                | 0                     |          |     |            |                                  | 8. 00            |
| 9.00             |   |                | 0                     |          |     |            |                                  | 9. 00            |
| 10.00            | Total additions (sum of line 4-9)   | 0              |                       |          | 0   |            |                                  | 10.00            |
| 11. 00           | Subtotal (line 3 plus line 10)  | O O            | 0                     |          | 0   |            |                                  | 11.00            |
| 12. 00<br>13. 00 | Deductions (debit adjustments) (specify) NET INTERCOMPANY TRANSACTIONS  |                | 0                     |          |     |            |                                  | 12. 00<br>13. 00 |
| 14. 00           | INET THTERCOMPANT TRANSACTIONS  |                | 0                     |          |     |            |                                  | 14. 00           |
| 15. 00           |   |                | 0                     |          |     |            |                                  | 15. 00           |
|                  |   |                | ŏ                     |          |     |            |                                  |                  |
| 16, 00           |   |                | ()                    |          |     |            | l                                | 16.00            |
| 16. 00<br>17. 00 |   |                | 0                     |          |     |            |                                  | 16. 00<br>17. 00 |
|                  | Total deductions (sum of lines 12-17)   | O              | 0                     |          | 0   |            |                                  |                  |
| 17. 00           | Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) | 0 0            | 0                     |          | 0   |            |                                  | 17.00            |

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1312

|                  |  | T           | o 12/31/2017 | Date/Time Pre 5/25/2018 5: 2 |                  |
|------------------|--|-------------|--------------|------------------------------|------------------|
|                  | Cost Center Description  | Inpati ent  | Outpati ent  | Total                        | <u> </u>         |
|                  | <b>'</b>   | 1.00        | 2. 00        | 3. 00                        |                  |
|                  | PART I - PATIENT REVENUES  | •           |              |                              |                  |
|                  | General Inpatient Routine Services                                       |             |              |                              |                  |
| 1.00             | Hospi tal  | 3, 160, 850 |              | 3, 160, 850                  | 1. 00            |
| 2.00             | SUBPROVI DER - I PF  |             |              |                              | 2. 00            |
| 3.00             | SUBPROVI DER - I RF  |             |              |                              | 3. 00            |
| 4.00             | SUBPROVI DER   |             |              |                              | 4. 00            |
| 5.00             | Swing bed - SNF  | 0           |              | 0                            | 5. 00            |
| 6.00             | Swing bed - NF   | 0           |              | 0                            | 0.00             |
| 7. 00            | SKILLED NURSING FACILITY   |             |              |                              | 7. 00            |
| 8. 00            | NURSI NG FACI LI TY  |             |              |                              | 8. 00            |
| 9.00             | OTHER LONG TERM CARE   | 0.4/0.050   |              | 0.440.050                    | 9. 00            |
| 10. 00           | Total general inpatient care services (sum of lines 1-9)                 | 3, 160, 850 |              | 3, 160, 850                  | 10. 00           |
| 11 00            | Intensive Care Type Inpatient Hospital Services                          | 1 0         |              | 0                            | 111 00           |
| 11.00            | INTENSIVE CARE UNIT  | 0           |              | 0                            |                  |
| 12. 00<br>13. 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT                              |             |              |                              | 12. 00<br>13. 00 |
| 14. 00           | SURGICAL INTENSIVE CARE UNIT   |             |              |                              | 14. 00           |
| 15. 00           | OTHER SPECIAL CARE (SPECIFY)   |             |              |                              | 15. 00           |
|                  | Total intensive care type inpatient hospital services (sum of lines      | 0           |              | 0                            |                  |
| 10.00            | 11-15)   |             |              | O                            | 10.00            |
| 17. 00           | Total inpatient routine care services (sum of lines 10 and 16)           | 3, 160, 850 |              | 3, 160, 850                  | 17. 00           |
| 18. 00           | Ancillary services   | 4, 295, 307 | 41, 504, 024 | 45, 799, 331                 | 18.00            |
| 19. 00           | Outpatient services  | 284, 777    | 22, 323, 754 | 22, 608, 531                 | 19. 00           |
| 20.00            | RURAL HEALTH CLINIC  | 0           | 0            | 0                            | 20. 00           |
| 21.00            | FEDERALLY QUALIFIED HEALTH CENTER  | 0           | O            | 0                            | 21. 00           |
| 22.00            | HOME HEALTH AGENCY   |             | o            | 0                            | 22. 00           |
| 23.00            | AMBULANCE SERVICES   |             |              |                              | 23. 00           |
| 24.00            | CMHC   |             |              |                              | 24. 00           |
| 25.00            | AMBULATORY SURGICAL CENTER (D. P. )                                      |             |              |                              | 25. 00           |
| 26. 00           | HOSPI CE   |             |              |                              | 26. 00           |
| 27. 00           | PHYSI CI AN REVENUE  | 0           | 357          | 357                          | 27. 00           |
| 28. 00           | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.   | 7, 740, 934 | 63, 828, 135 | 71, 569, 069                 | 28. 00           |
|                  | G-3, line 1)   |             |              |                              |                  |
| 29. 00           | PART II - OPERATING EXPENSES   | I           | 24, 933, 671 |                              | 1 20 00          |
| 30. 00           | Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)       | 0           | 24, 933, 671 |                              | 29. 00<br>30. 00 |
| 31. 00           | (SPECIFY)  | 0           |              |                              | 31.00            |
| 32. 00           |  | 0           |              |                              | 32.00            |
| 33. 00           |  | 0           |              |                              | 33. 00           |
| 34. 00           |  | 0           |              |                              | 34. 00           |
| 35. 00           |  | 0           |              |                              | 35.00            |
| 36. 00           | Total additions (sum of lines 30-35)                                     |             | o            |                              | 36. 00           |
| 37. 00           | DEDUCT (SPECIFY)   | 0           | ]            |                              | 37. 00           |
| 38. 00           |  | 0           |              |                              | 38. 00           |
| 39. 00           |  | 0           |              |                              | 39. 00           |
| 40.00            |  | 0           |              |                              | 40. 00           |
| 41.00            |  | 0           |              |                              | 41. 00           |
| 42.00            | Total deductions (sum of lines 37-41)                                    |             | 0            |                              | 42. 00           |
| 43.00            | Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer |             | 24, 933, 671 |                              | 43. 00           |
|                  | to Wkst. G-3, line 4)  |             |              |                              |                  |

|        | <u> </u>  | U HEALTH WHITE HOSPITAL     |                             | u of Form CMS-2 |        |
|--------|---|-----------------------------|-----------------------------|-----------------|--------|
| STATEM | ENT OF REVENUES AND EXPENSES                    | Provider CCN: 15-1312       | Peri od:<br>From 01/01/2017 | Worksheet G-3   |        |
|        |   |                             | To 12/31/2017               | Date/Time Pre   | nared· |
|        |   |                             | 10 12/01/2017               | 5/25/2018 5: 20 |        |
|        |   |                             |                             |                 |        |
|        |   |                             |                             | 1. 00           |        |
| 1.00   | Total patient revenues (from Wkst. G-2, Part I, |                             |                             | 71, 569, 069    |        |
| 2.00   | Less contractual allowances and discounts on pa | atients' accounts           |                             | 47, 904, 391    |        |
| 3.00   | Net patient revenues (line 1 minus line 2)      |                             |                             | 23, 664, 678    |        |
| 4.00   | Less total operating expenses (from Wkst. G-2,  |                             |                             | 24, 933, 671    |        |
| 5.00   | Net income from service to patients (line 3 mir | nus line 4)                 |                             | -1, 268, 993    | 5. 00  |
|        | OTHER INCOME                                    |                             |                             |                 |        |
| 6.00   | Contributions, donations, bequests, etc         |                             |                             | 0               |        |
| 7.00   | Income from investments                         |                             |                             | 0               |        |
| 8.00   | Revenues from telephone and other miscellaneous | s communication services    |                             | 0               |        |
| 9.00   | Revenue from television and radio service       |                             |                             | 0               |        |
| 10.00  | Purchase di scounts                             |                             |                             | 0               | 1      |
| 11.00  | Rebates and refunds of expenses                 |                             |                             | 0               | 1      |
|        | Parking Lot receipts                            |                             |                             | 0               | 1      |
| 13.00  | Revenue from Laundry and Linen service          |                             |                             | 0               | 13. 00 |
| 14.00  | Revenue from meals sold to employees and guests | S                           |                             | 0               | 14. 00 |
| 15.00  | Revenue from rental of living quarters          |                             |                             | 0               | 15. 00 |
| 16.00  | Revenue from sale of medical and surgical suppl | lies to other than patients |                             | 0               | 16. 00 |
| 17.00  | Revenue from sale of drugs to other than patier | nts                         |                             | 0               | 17. 00 |
| 18.00  | Revenue from sale of medical records and abstra | acts                        |                             | 0               | 18. 00 |
| 19.00  | Tuition (fees, sale of textbooks, uniforms, etc | c. )                        |                             | 0               | 19. 00 |
| 20.00  | Revenue from gifts, flowers, coffee shops, and  | canteen                     |                             | 0               | 20.00  |
| 21.00  | Rental of vending machines                      |                             |                             | 0               | 21. 00 |
| 22.00  | Rental of hospital space                        |                             |                             | 0               | 22. 00 |
| 23.00  | Governmental appropriations                     |                             |                             | 0               | 23. 00 |
| 24.00  | MI SCELLANEOUS I NCOME                          |                             |                             | 911, 174        | 24.00  |
| 25. 00 | Total other income (sum of lines 6-24)          |                             |                             | 911, 174        |        |
|        | Total (line 5 plus line 25)                     |                             |                             | -357, 819       |        |
|        | OTHER EXPENSES (SPECIFY)                        |                             |                             | 0               | 1      |
|        | Total other expenses (sum of line 27 and subscr | ripts)                      |                             | 0               |        |
|        | Net income (or loss) for the period (line 26 mi |                             |                             | -357, 819       |        |